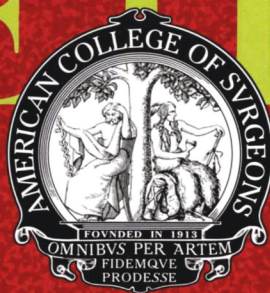


BULLETIN

AMERICAN COLLEGE OF SURGEONS



August 2001
Volume 86, Number 8

HAITI: A CALL TO CARE



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About the cover...

Haiti is the one of most impoverished countries in the world, and, as a result, is in great need of volunteer medical assistance. William R. Greene, MD, FACS, a urologist in Myrtle Beach, SC, heard a "call to care" and went to Haiti recently to provide such outreach surgical services. In his article (p. 8), he describes why he chose to lend his skills to the people of Haiti, how he gathered supplies for the expedition, and the ways in which this experience improved the quality of life for both his Haitian patients and himself.

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From my perspective

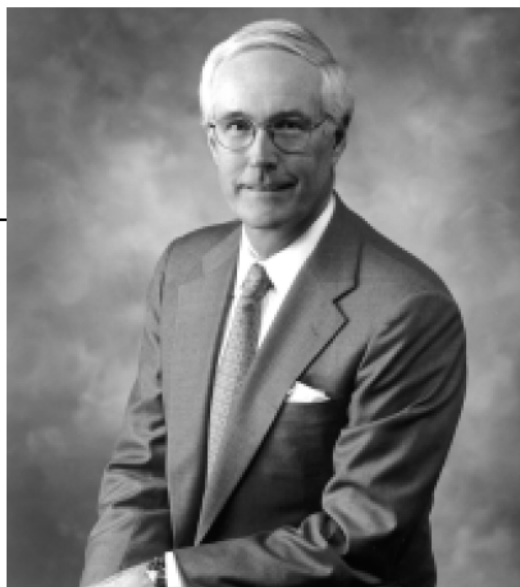
At press time, many notable events were occurring in the health care arena. For example, the American Medical Association (AMA) had just held its House of Delegates meeting in Chicago, IL. During that meeting, E. Ratcliffe "Andy" Anderson, Jr., MD, the AMA's chief executive officer, filed a lawsuit for breach of contract against the organization and another for defamation against the chair-elect of the AMA Board of Trustees. Simultaneously, Congress was debating legislation to establish a patients' bill of rights with a particular focus on the issue of holding managed care organizations liable for decisions made with regard to patient care.

With all that going on, it is a pleasure to report that a more positive, enthusiastic, and constructive outcome emanated from the College's Board of Regents business meeting and special retreat, which took place June 8-10. This meeting centered on bringing to fruition some of the goals and objectives identified during the College's strategic planning process, which has been under way for more than a year now.

One of the major charges I was given by the Board of Regents when I became Executive Director was to undertake a strategic planning process and to review the College's financial health to ensure that we can continue to provide the same level of service to our members and add important new programs. This process has incorporated both an internal review of the College's organizational structure and activities, as well as a survey of a sample of the Fellowship. The Regents were presented with some of the preliminary findings from these studies, and their discussion of these matters led to the generation of new approaches to many of the College's programs and our organizational structure. Of course, implementation of some of these programs will involve considerable expense. However, the Regents feel that the investment we make in these endeavors will result in a stronger organization that will better serve Fellows and their patients now and in the future. Some of the more significant topics on which the Regents acted or made recommendations are described in the following paragraphs.

Reorganization

Perhaps most significantly at this juncture, the Regents approved a reorganization plan for the



“Much of what the College seeks to achieve through this...reevaluation process is identification of our common ground.”

College. Under this schematic, the College's resources and activities will no longer be focused on individual departments' activities, but will be concentrated on the following four areas: education, research and optimal patient care, health policy and advocacy, and member services. We anticipate that this new structure will ensure that the College will focus more attention on the issues of greatest concern to our members, as identified through our survey of nearly 2,500 active Fellows, and that the College will function in a more unified, cohesive manner.

Educational programming

Many of the Fellows who participated in the survey complimented the College's educational programs. Nonetheless, the respondents called for more courses on practice-related issues, such as physician reimbursement, medical errors and patient safety, professional liability and tort reform, and managed care. We will be reviewing and analyzing the survey results more extensively over the coming months. Through this analysis, we anticipate an enhanced ability to customize and further develop many educational programs that will help

surgeons improve patient care and their ability to practice surgery.

Electronic communication

According to the Fellowship survey, use of e-mail and the Internet has risen dramatically in the last several years. The College will continue to examine both the current use of computer and electronic communications technologies and to explore attitudes and preferences with regard to future uses.

Enhanced data collection

The Regents gave a great deal of consideration to the external environment affecting surgery, including the recently released report from the Institute of Medicine calling for the redesign of the nation's health care system. During these conversations, it became very clear that the accumulation and application of data will become increasingly important as we enter an era demanding more scientific evidence supporting medical decisions. To this end, the Regents enthusiastically supported the continued development of an ACS Office of Evidence-Based Surgery. This office will be responsible for processing and evaluating data leading to best practices and, possibly, clinical trials in areas other than oncology. This will be an expensive endeavor, requiring additional statistical support and personnel. Even so, this effort is an important and timely one, and the Regents believe we should move forward with it.

On a related note, the Regents offered uniform support for improving the quality and quantity of data collected and disseminated through the College's National Trauma Data Bank™ and its software component, National TRACS®. By enhancing this capability, the College will be able to produce data to complement many of our trauma programs.

Tax status

Over the last several months, several of our Governors' and Regental committees have had lively debates about the benefits of changing the College's tax status. We traditionally have functioned as a tax-exempt 501(c)3 entity, a status that has served us well over the years given that our primary focus has been on education. However, the majority of surgeons who participated in the Fellowship survey indicated that the College should be more

involved in advocating on their behalf. By moving to a 501(c)6 status, the College could have a more far-reaching impact on legislation and better access to lawmakers who can have an influence on issues affecting all surgeons, regardless of specialty.

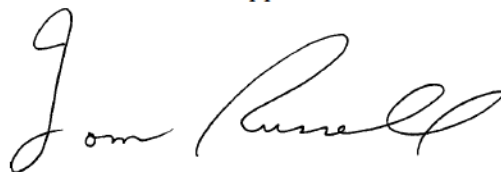
"Branding"

Another central concept at this point is "branding" the term "Fellow of the American College of Surgeons (FACS)." Serious consideration is being given to a program that would help the College attain "brand-name" recognition. Certainly, surgeons have long known that the acronym "FACS" indicates that the individual bearing it has demonstrated the highest level of training and professional values. Many patients, however, do not yet make this association. Hence, we need to convey the purposes and standards of this organization to the public so they can make informed decisions about surgical care and will seek out the services of Fellows either for operative procedures or for advice on treatment options.

Continuing to chart the course

So much is going on in medicine these days, and the College needs to take advantage of the opportunities that exist to bring all of surgery together. Regardless of specialty, we all have so much in common. Yet over the years, we have not seized upon our similarities but on our differences. Much of what the College seeks to achieve through this reorganization and reevaluation process is identification of our common ground and unification of all specialties under one surgical umbrella.

In the near future, the entire strategic plan for the College will be available to the Fellowship, and we will continually refer to this blueprint and refine it as the organization evolves. As always, your thoughts and views will be appreciated



Thomas R. Russell, MD, FACS

If you have comments or suggestions about this or other issues, please send them to Dr. Russell at fmp@facs.org.

FYI: *STAT*

This column provides brief reports on important items of interest to members of the College. It will appear in the Bulletin when there is "hot news" to report. In-depth coverage of activities announced here will appear in columns and features published in the Bulletin and in the College's weekly electronic newsletter, ACS NewsScope.



Thomas R. Russell, MD, FACS, ACS Executive Director, and ACS President-Elect R. Scott Jones, MD, FACS, participated in **an event hosted by President George W. Bush** at the White House on July 11. During the function, the President addressed the importance of patient access to specialty care.



An official College **Statement on Diversity**, which was developed by the Board of Governors Committee on Chapter Activities, was approved by the Board of Regents earlier this year. The statement can be found on page 24 of this issue of the *Bulletin*.



On July 20, Thomas R. Russell, MD, FACS, hosted a meeting of leaders and staff of two dozen surgical specialty societies in Washington, DC. The meeting was a **Medicare Reform Symposium**, during which representatives of the insurance, medical device, and pharmaceutical industries, as well as the beneficiary community, presented their perspectives on changes needed in the Medicare program. Also participating in the event was Sen. Bill Frist, MD, FACS (R-TN), coauthor of one of the principal Medicare reform proposals pending before Congress.



The American College of Surgeons Commission on Cancer (CoC) has completed collaboration with the American Cancer Society on a major cancer prevention effort designed to augment detailed lifestyle and nutrition epidemiologic data using blood samples to study hormone and vitamin levels, as well as DNA. June 4, 2001, results of this voluntary partnership, known as the **LifeLink Blood Collection Study**, show that 39,400 blood samples were obtained. CoC State Chairs worked with cancer liaison physicians at 312 CoC-approved cancer programs in 20 states to gain hospital approval for the study and to make arrangements for study participants to provide a blood sample close to home. For more information, contact Joanne Sylvester at jsylvester@facs.org.



The American College of Surgeons will hold its **87th annual Clinical Congress** October 7-12, 2001, in New Orleans, LA. Details, including programming information for the surgical specialties and an online registration form, are available at: <http://www.facs.org/2001clincon/reg/reg.html>.

Dateline|Washington

prepared by the Washington Office, Health Policy and Advocacy Department

Medicare agency announces changes

On June 14, Secretary of Health and Human Services (HHS) Tommy Thompson announced a reorganization and a new name for the Health Care Financing Administration (HCFA). As part of an agency overhaul, HCFA will now be known as the Centers for Medicare and Medicaid Services (CMS)—which will actually be an umbrella for three centers, each appropriately named to clearly reflect what it does and how it serves millions of Americans.

- The Center for Beneficiary Choices will focus on the Medicare+Choice program and will provide beneficiaries with information they need to make the best choice possible in selecting care.

- The Center for Medicare Management will focus on the traditional fee-for-service Medicare program.

- The Center for Medicaid and State Operations will focus on programs administered by the state, including Medicaid, the State Children's Health Insurance Program, and insurance regulation.

That same week, Secretary Thompson announced his intentions to reduce regulatory burdens in health care and to respond more quickly to the concerns of providers and state and local governments. HHS will create a cross-departmental Task Force on Regulatory Reform to steer ongoing review of HHS regulations and to oversee changes in regulations. The work of this group will include an expanded review of Medicare and Medicaid regulations, as well as a review of the extensive cost reports that Medicare hospitals are required to file with the agency. The Secretary also pledged to work with the members of Congress to reduce regulatory burdens through legislation.

Finally, the Secretary testified during a June 19 Senate Finance Committee hearing on Medicare governance that, before the end of the year, CMS will begin publishing a quarterly compendium of Medicare instruction changes. In addition, he said the agency would limit regulation publishing to once a month. The move is intended to help providers stay informed about new regulations and to reduce the time and effort they spend combing through the *Federal Register* for new policies that affect them.

MedPAC raises concerns about physician payment update

In its June report to Congress, *Medicare in Rural America*, the Medicare Payment Advisory Commission (MedPAC) reviewed CMS's estimate for the 2002 payment update for physician services. Although MedPAC believes that the agency's current estimate of a -0.1 percent payment update is reasonable, commission members commented that, for a number of reasons, the update for 2002 "may ultimately be lower—perhaps significantly lower—which could raise concerns about the adequacy of payments and beneficiary access to care." MedPAC also criticized the sustainable growth rate (SGR) system, which is designed to control overall spending for physician services in the Medicare fee-for-service program. In discussing the SGR, the commission stated that the system "fails to account adequately for changes in the cost of physician services and that policymakers should consider alternatives to the system if policies to control spending are necessary."

Medicare issues five-year review proposal

A proposed rule on the “five-year review” of the Medicare fee schedule physician work values, published in the *Federal Register* on June 8, predicts that many surgical specialties will receive modest payment increases in the coming year as a result of changes that are planned for the values assigned to some of their services. For example, it is estimated that average Medicare payments to cardiac surgeons will increase 6 percent; payments for thoracic surgeons will rise 5 percent; general surgery payments will go up 4 percent; and vascular surgery will increase 2 percent. The general surgery work value increases were based on a “building block” methodology developed by the College’s General Surgery Coding and Reimbursement Committee.

The precise impact of the new work values will become more clear later this summer, after CMS issues its proposed rule on the 2002 Medicare fee schedule. That draft regulation will include any planned changes in payment policies, as well as the fully implemented resource-based practice expense relative work value units.

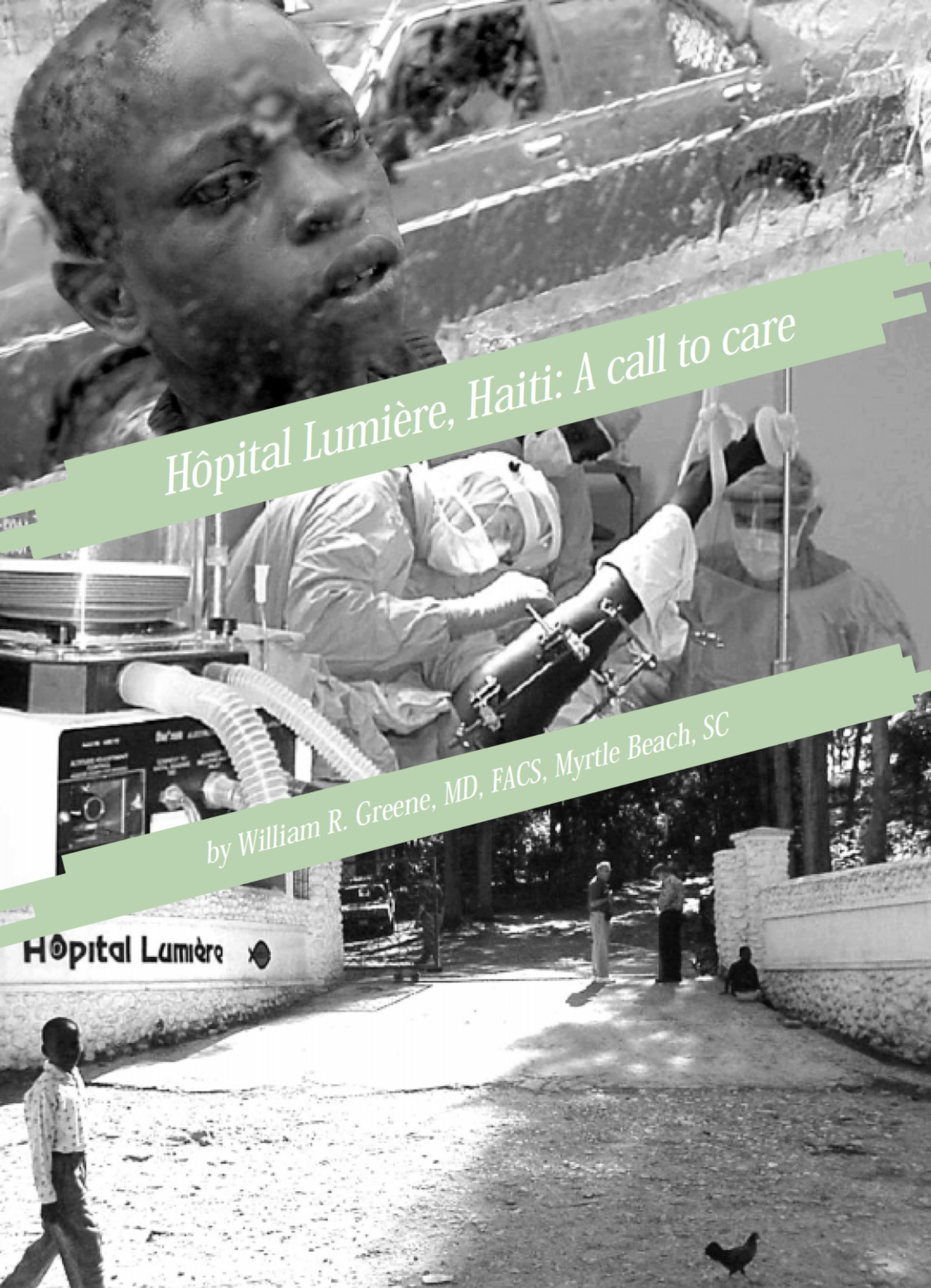
HHS issues guidance on patient privacy protections

On July 6, HHS issued the first in a series of guidance material on new federal privacy protections for medical records and other personal health information. The material is intended to explain and clarify key provisions of the medical privacy regulation, which was published last December. Topics include patient consent, parental rights, marketing, medical research, and governmental access issues.

The guidance answers common questions about the new protections for consumers and requirements for doctors, hospitals, other providers, health plans, and health care clearinghouses. It also clarifies the meaning of key provisions of the rule. For example, the guidance states that hospitals do not have to build private, soundproof rooms to prevent overheard conversations about a patient’s condition as some mistakenly believed. The guidance also indicates that the rule allows a friend or relative to pick up a patient’s prescription at the pharmacy, as often occurs today.

Most covered entities have until April 14, 2003, to comply with the patient privacy rule; small health plans have an additional year to comply. HHS’s Office for Civil Rights will conduct extensive outreach to consumers and health care providers to explain what the rule means to them. The department also will provide technical assistance and further guidance to health care providers and other covered entities to help them comply.

A fact sheet summarizing the privacy rule’s rights and protections is available at <http://www.hhs.gov/news/press/2001pres/01fsprivacy.html>. More detailed information about the rule, including the initial guidance, is available at <http://www.hhs.gov/ocr/hipaa>.



Hôpital Lumière, Haiti: A call to care

by William R. Greene, MD, FACS, Myrtle Beach, SC

Hôpital Lumière

On Wednesday night I was alone on rounds at Hôpital Lumière, Haiti, when a nurse called, "Doctor, come quickly to the pediatric ward." A four-year-old child, who had been admitted for a hernia repair the next morning, was unconscious in respiratory distress. I went running but was inwardly frightened. I hadn't studied pediatrics in 30 years. When I arrived, the girl was unconscious. We gave her oxygen, but I felt helpless. Our first medical dictum kept running through my mind: *Primum non nocere*. I prayed that someone who knew what to do would soon arrive, but no one did. The lights kept going off, so we worked by flashlight.

Two weeks before my trip to Haiti, I had attended a refresher course on advanced cardiac life support. I clearly remembered that codes generally are called on adults for cardiovascular disease. Children, however, die more often from respiratory distress, so I knew that this was a critical situation. I recognized that the child suffered from bronchospasm. In retrospect, she had been given intravenous fluids that were probably outdated and contaminated. Her pulse oximeter dropped to 75. I had no choice but to do something. Without knowing the pediatric doses, I titrated small amounts of epinephrine intravenously. Slowly she responded. Later the internist arrived; he had nothing further to recommend for the child. She was smiling with her mother when I made rounds the next morning. I knew that she was one of the reasons I answered the call to be in Haiti.



This young Haitian girl nearly died from respiratory distress caused by contaminated IV fluids.



Homes were huts with dirt floors and branches for walls and roof.

The call

My journey to the island of Hispaniola began more than two years earlier. After 23 years in a satisfying urology practice, I experienced an increasing sense of frustration, a lack of fulfillment



"At 4:15 am we left on the most miserable journey of our lives." From left to right: Dr. Jarrett, Mr. Long, Dr. Greene, and Dr. Cunningham.

in my daily routines. In retrospect, I know that there was a very gentle call to search in another direction. After a year of investigation, I read an article in the September 1998 issue of the *Bulletin* by Douglas W. Soderdahl, MD, FACS. At age 56, he retired from his urology practice to undertake full-time missionary work. His wife is his scrub nurse, and they travel the world together, treating the poorest of the poor and teaching urologic surgery skills to general surgeons. At the American Urological Association national meeting in Dallas, TX, I shared a room with this marvelous missionary, who has become my mentor.

Initially, I was hesitant to commit to similar work. There seemed to be so many uncertainties, so many dangers. During that week of discussion and reflection, however, my confidence and enthusiasm grew. One memorable morning while in prayer, I came to realize that, if God calls one to service, there is no reason to fear the unknown. My commitment was secure that day, but it took another year to find the right opportunity.

I have talents in urology, which cannot be adequately utilized working out of a tent or the back of a truck. One day, Joe Jarrett, MD, FACS, an orthopedic surgeon in my community who had

worked in Haiti twice before, asked if I would like to join him on his next trip. After seeing his slide presentation, I knew this was the right opportunity.

Outpouring of generosity

Preparing for the trip, set for August 26 through September 3, 2000, required a lot of hard work. Most importantly, I appealed on behalf of the people of Haiti for the medical supplies and equipment that would be needed. I was overwhelmed by the response from the individuals and companies I contacted. Not one refused to participate, and most responded far more generously than I ever would have expected: Johnson & Johnson loaned us a \$54,000 Indigo Laser and donated \$12,000 in laser fibers to treat benign prostatic hypertrophy;

Olympus lent \$20,000 worth of endoscopic equipment; Valley Lab supplied a \$7,000 electrocautery unit; Eli Lilly donated over \$800 in medications; and Interchurch Medical Assistance and MAP International provided \$10,000 in medication at a cost of \$1,200. The Myrtle Beach Rotary Clubs underwrote these expenses. My hospital, Grand Strand Regional Medical Center, offered to give us whatever we requested. The list of benefactors goes on and on.

A heartwarming experience came from Leatherman Tools in Oregon. Months before the trip I wanted to purchase some meaningful gifts for people who extended a special effort in helping me on my mission. I realized how useful my Leatherman Tool is to me. This is a wonderfully engineered instrument similar to a Swiss Army Knife; it is a complete toolbox in a single instrument that I can't live without. It retails for \$40. I wrote to the president of the company, Timothy Leatherman. I explained my medical mission and asked if I could purchase a half-dozen of his valuable tools as gifts at wholesale. Three weeks later he wrote back that he could not provide tools at a wholesale price, but enclosed two dozen of his tools for my journey.

For a trip like this to take place, so many details must fall into place. I am blessed with surgical training and skills and the desire to share my talents with others. I needed and received the support of my wife and my daughter. They probably thought I was a bit crazy but did not object. My practice needed coverage in my absence; fortunately I have five partners to take over the workload. I would need to shoulder the expenses for the trip. This was not a significant problem, and, to my surprise, I received financial support I did not even request.

The journey begins

Although Hurricane Debbie threatened our travel plans, we set out at 4:15 am on the most miserable journey I have ever made. I was accompanied by Dr. Jarrett, Calhoun Cunningham, MD, FACS, an otorhinolaryngologist, and Donnie Long, an orthopaedic operating room technician. Our first concern was our baggage; we had 14 large boxes and duffle bags, far more than the airlines allowed. When the attendant read we were medical missionaries, he loaded all the bags without comment. When we arrived in Atlanta, GA, the agent learned of our mission and gave us first-class accommodations, including a delicious breakfast (the last meal of the trip we could describe as delicious).

On the flight from Miami, I had the opportunity to talk with a Haitian schoolteacher in her native French language. I learned from her that Haiti is the third-poorest country in the world. Due to decades of political corruption, no significant industry has survived, and the infrastructure has deteriorated. Per capita income is \$500 per year; life expectancy is 51 years. Haiti has the highest HIV rate in the western hemisphere. Two-thirds of the people are illiterate and 60 percent go to bed hungry each night. Medical care is primitive, relying upon itinerant specialists to supplement the work of Haitian-trained primary care physicians and missionaries.

The most frightening part of the journey awaited us at the airport in Port-au-Prince. Groups of baggage attendants/gangsters fought to grab our bags. It was customary to expect one American dollar each time an attendant touched a travel bag. We could see our valuable cargo going off in many different directions. We had to fight back to avoid los-

ing everything. We learned on our departure that the Haitian airport is the least secure airport in the entire world.

It took six hours in a truck with a very aggressive driver to travel 120 miles to the village of Bonne Fin and Hôpital Lumière. Some roads were paved, but many were washed-out river beds with deep ditches and boulders as large as footballs. Our driver would weave from one side of the road to the other; he took us down paths that were never meant for motorized vehicles. We barely missed hitting pedestrians, cyclists, and animals along the path.

We witnessed almost indescribable poverty. People live in shanties with slabs of tin as roofs and plywood or branches for walls. Each village has a central well, and water is carried on the top of the women's heads to the homes. Garbage covers the island, and the air has the stench of charcoal burning. We had taken our immunizations and malaria pills. We were warned not to drink the water, and we took Pepto-Bismol to avoid traveler's diarrhea.

The hospital is in the village of Bonne Fin (translated this means "Happy Ending," which was what we experienced after 16 hours of traveling). It was developed by a family practitioner, G. Dudley Nelson, MD, from California in 1973. It would be considered outdated by U.S. standards but represents a monumental effort built in a Third-World country. The compound is protected by a tall brick wall and guards armed with rifles. Our residence was a cinder-block building with non-potable, cold running water and electricity during daylight hours. The utilities in the compound and the hospital were interrupted many times each day. We had plenty of roaches and lizards sharing the quarters. Food was basic but satisfying. My most memorable meal consisted of mashed potatoes, rice, French fries and bread. We had chicken a few times, and I really developed a liking for goat meat. It tastes like barbecued pork but is tougher and less greasy.

Our most valuable possessions were five-gallon vinyl water bags. We would fill them from a slowly dripping faucet in the morning and hang them in the sun all day. When we returned late at night, the water and electricity were off, but we were assured a marvelous shower before retiring. On a special shelf, we kept \$700 of AIDS drugs donated by

Contacts

The call to care for patients in Haiti, and the Third World in general, will never be fully satisfied. All specialties are in demand. To respond to this gentle call to volunteer your services, the following organizations may be helpful:

World Medical Mission: 828/262-1980

United Methodist Volunteers In Mission:
sejumvim.compuserve.com

Mercy Ships: mercyships.org

International Volunteers in Urology:
ivumed.org

Physicians for Peace: physiciansforpeace.org

AmeriCares: 203/966-5195

International Medical Corps: 310/826-7800

Northwest Medical Teams: 503/624-1000

Catholic Medical Association:
cathmed@cathmed.com

our hospital back home to use as prophylaxis if we were cut or stabbed with a needle during surgery. The drug supply reminded us that we were playing for keeps; thankfully, no one needed to use these medications.

The day generally began with breakfast at 7:00 am followed by chapel service at 7:30 am for the hospital staff. Physicians and nurses usually presented testimony or Bible readings. The U.S. doctors sat in the back, and a member of the congregation would always come to sit behind us and translate from the native Creole into English. On the last day we were there, I mustered the courage to offer witness with translation by my friend, Ronald Jean Luis, MD, a Haitian general surgeon.

About 90 percent of Haitians are nominal Catholics who also practice voodoo—a form of African animism. Before surgery, the Catholics would offer prayers to the Christian God and voodoo

prayers, as well, to be certain all bases were covered. Unfortunately, the voodoo doctors frequently were the first line of health care; patients who failed to recover with their potions and rituals were then brought to the hospital in more serious condition. In the case of high-risk pregnancy, the baby often was dead by the time a medical doctor was seen. There are many Baptist churches on the island, and Baptist missionaries run the hospital compound. During the services we attended, I was impressed with the sincerity of the peoples' prayers and hymns and the depth of their faith. They offered thanks to God for the gifts bestowed upon them, meager as they were. "Amazing Grace" was easily recognizable in Creole. The pastor introduced us to the congregation as the visiting American surgeons, and we received a hearty round of applause.

The hospital normally has 60 beds. For two weeks before our trip, the local radio channels announced the anticipated arrival of surgeons from the U.S. Patients walked for miles to be seen; Hôpital Lumière was overflowing with dozens of patients sleeping in the halls and in the clinics. Our day ran from 8:00 am until 5:00 pm in the operating room, a surgeon's dream. I would go for dinner at 6:00, and return for rounds and pre-op evaluations until 10:30 or 11:00 pm. I had a group of six sixth-year medical students from Port-au-Prince who worked with me. They were hungry for medical education: I would teach as much as possible, especially from 10:00 to 11:00 pm. One student, Rolf, spoke beautiful English and served as my translator with patients. He received one of my Leatherman Tools.

The hospital was staffed by one general surgeon, two internists, a pediatrician, an obstetrician-gynecologist, and several nurse anesthetists who were excellent. We were given unrestricted use of the four operating rooms. I had the opportunity to perform 27 urologic operations.

Unique challenges

Surgical experiences in a Third-World operating room presented unusual challenges. The temperature averaged 90 degrees. At the end of every case, we would be drenched in perspiration from the neck to the ankles. There was no reason to change scrubs, because we would be drenched again after the following case. Open windows were the only

source of ventilation; the screens had holes, and flies in the operating theater were common. We always irrigated well at the end of each case. The combination of patients with hearty lifestyles and few antibiotic-resistant organisms protected us from serious infections.

In the United States, central sterile supply is always neat and well-organized; in Haiti there was chaos. Instead of instruments arranged on shelves in cabinets, there was a "central mound" two feet high and four feet wide with all of the surgical instruments. We would rummage through the inventory to find what we would need for each case. A gynecologist colleague, Ben Martin, MD, had worked at Lumière the preceding year. He donated a retractor that was sorely needed. By our fourth day in-country, pieces of the retractor had been lost, and it was no longer functional. The hospital pharmacy was limited and disorganized. They did not have a formulary and were unsure of the medications available. Postoperative analgesics were almost nonexistent; fortunately we brought our own supply of IV Toradol. Attempts have been made to educate the Haitians about organization and planning. Unfortunately, the culture and level of education are not conducive to outside influence, so life goes on with little change.

Memorable cases

There are so many personal stories I could relate. I was presented with a patient with kidney cancer diagnosed only by ultrasound. We performed a radical nephrectomy under the most difficult conditions. This was truly a leap in faith. There was very poor lighting in the operating room, and we had limited instruments. We fashioned a gallstone scoop to serve as a vein retractor when we had trouble identifying the renal artery. At one frustrating point in the surgery, I prayed for help. I recalled the story "Footprints" and one set of tracks in the sand. The patient did remarkably well, and I am confident he is now cured.

Two women had vesicovaginal fistulas repaired transabdominally. An older man was in kidney failure with advanced prostate cancer. Most Haitians do not live long enough to develop prostate cancer. I removed his testicles and reversed his renal failure (at least temporarily). Another man had a giant hydrocele. I drained five liters of fluid from



Dr. Jean Luis (left) and Dr. Greene.

his scrotum. It is hard to imagine that he had been carrying 10 pounds of fluid between his legs for years.

Benign prostatic hypertrophy is a common malady in a Third-World country with few urologists. I performed 14 operations on men who had been in urinary retention and wore catheters for months. These patients had very large prostate glands and usually required a transurethral resection of prostate (TURP)—a major undertaking in Haiti. Most patients were anemic and would likely require transfusion from a blood bank tainted with the threat of AIDS. Fortunately, I made use of the donated laser and was able to perform the surgery very safely with the newest technology. Instead of cutting away the tissue, the laser fiber was inserted into the adenoma and heat destroyed the obstructing tissue. No patients were transfused. Although the hospital staff was accustomed to postoperative hemorrhage and clot retention, they were pleasantly surprised with interstitial laser prostatectomy. The students asked if this blue box was American magic. I told them, "No, this is American voodoo."

Dr. Jean Luis is an inspiring figure. He is a tall, handsome, Haitian-trained general surgeon, a compassionate physician and skilled technician



This boy with rickets walked on his toes because of his condition.

who works tirelessly for his people. In the absence of visiting specialists, he is responsible for all surgical cases that arrive at Hôpital Lumière. He is a classic general surgeon, with expertise in all surgical specialties. If he cannot handle a critical case, the patient will die. When I visited, the ob/gyn surgeon was on vacation, so Dr. Jean Luis was busy with cesarian sections and vaginal deliveries. He knew details on each of the inpatients and worked unending hours in the hospital.

One morning in chapel, we had three visiting dignitaries. They were ministers from surrounding provinces who gave sermons. I was asked to delay my surgery that morning, to attend to their urologic needs. I saw each individually in the clinic. Two had come to have their Viagra prescriptions refilled.

The "poster child" of our trip was a boy of approximately 10 years, who suffered from rickets. His femurs met the tibias at the knees at an angle of 90 degrees. He walked with extreme difficulty on his toes. Dr. Jarrett performed rotational osteotomies on the tibia and fibula bilaterally, straightened the legs, and applied external fixation, without the use of intraoperative X ray. The boy would remain in the hospital for three months until the next orthopaedic surgeon arrived to re-

move the fixation and begin rehab.

On a late Thursday night with my entourage, I again heard the question, "Doctor, would you see just one more patient?" They brought in a beautiful eight-month-old child with his mother. As they undressed the boy, I was the only one in the room who recognized that he suffered from the most devastating urological birth defect: exstrophy of the bladder. In this condition, the bones of the pelvis fail to close and the pubic bones remain widely separated. The bladder lays open on the lower abdominal wall pouring urine. The penis and scrotum are split; epispadias leaves the urethra open on the dorsum of the penis. The testicles do not descend to the normal position. After explaining the condition to my students, I reassured Dr. Jean Luis that there was no immediate emergency. I would make sure that he would receive sophisticated surgical correction when I returned home. I have been in contact with Charles Horton, MD, FACS, the founder of Physicians for Peace in Norfolk, VA. We have now made arrangements for a department chairman of urology, who has an upcoming trip scheduled for Haiti, to perform the major reconstructive surgery in-country.

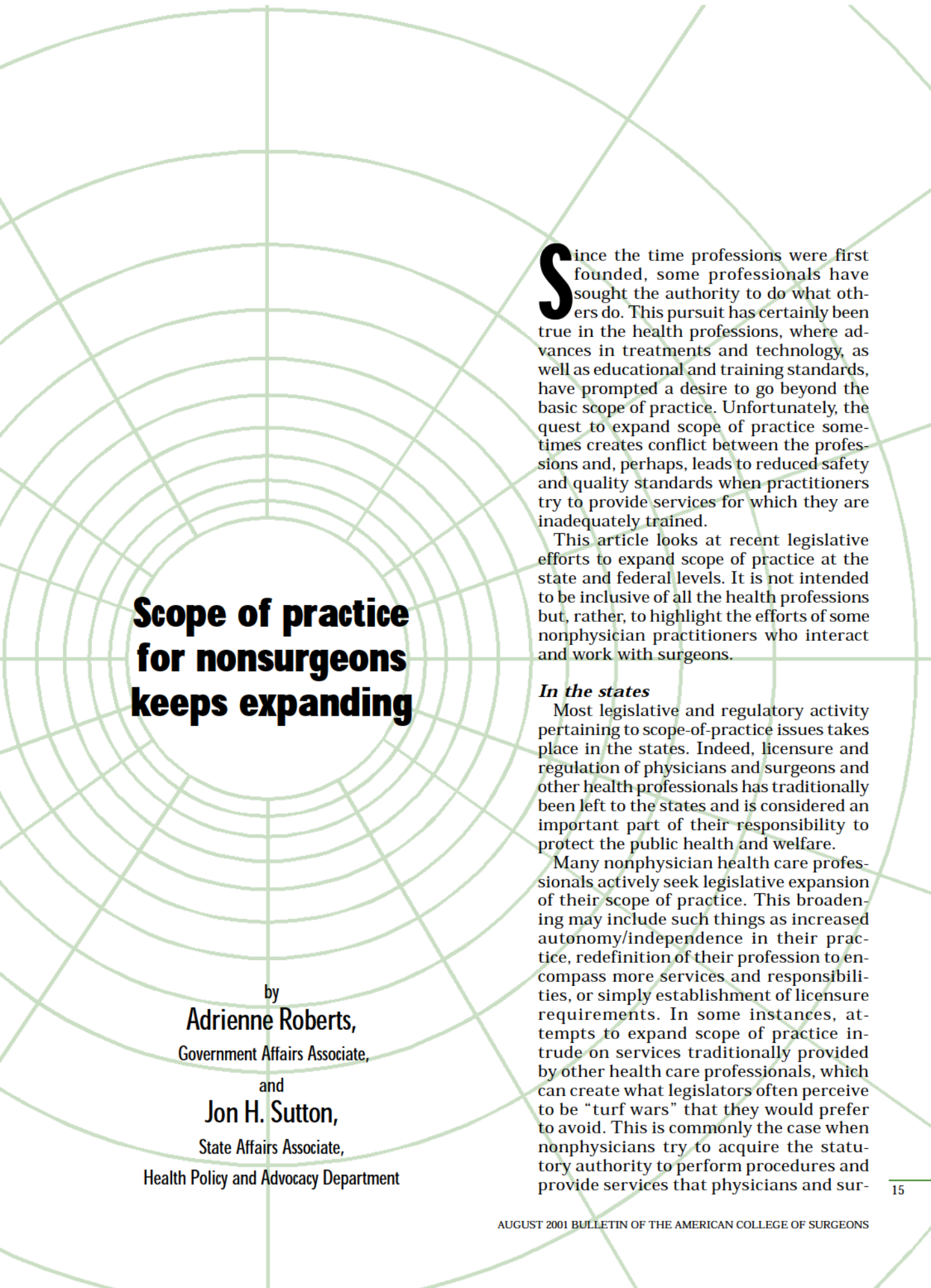
Satisfaction and inner peace

On Saturday morning at 5:00 am, the four of us left for the trip home. I told Dr. Jean Luis earlier that I had expected to work very hard; I left totally drained. But what a marvelous feeling of satisfaction and inner peace. We performed 52 operations and succeeded in clearing the hospital of all of the surgical patients who required our attention. Mi-

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Scope of practice for nonsurgeons keeps expanding

by
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Since the time professions were first founded, some professionals have sought the authority to do what others do. This pursuit has certainly been true in the health professions, where advances in treatments and technology, as well as educational and training standards, have prompted a desire to go beyond the basic scope of practice. Unfortunately, the quest to expand scope of practice sometimes creates conflict between the professions and, perhaps, leads to reduced safety and quality standards when practitioners try to provide services for which they are inadequately trained.

This article looks at recent legislative efforts to expand scope of practice at the state and federal levels. It is not intended to be inclusive of all the health professions but, rather, to highlight the efforts of some nonphysician practitioners who interact and work with surgeons.

In the states

Most legislative and regulatory activity pertaining to scope-of-practice issues takes place in the states. Indeed, licensure and regulation of physicians and surgeons and other health professionals has traditionally been left to the states and is considered an important part of their responsibility to protect the public health and welfare.

Many nonphysician health care professionals actively seek legislative expansion of their scope of practice. This broadening may include such things as increased autonomy/independence in their practice, redefinition of their profession to encompass more services and responsibilities, or simply establishment of licensure requirements. In some instances, attempts to expand scope of practice intrude on services traditionally provided by other health care professionals, which can create what legislators often perceive to be "turf wars" that they would prefer to avoid. This is commonly the case when nonphysicians try to acquire the statutory authority to perform procedures and provide services that physicians and sur-

geons consider the practice of medicine.

Legislators also are faced with health care expenditure and access issues, and many allied health professionals are very successful in making the case that they provide essentially the same services safely and at less cost. In addition, allied health professionals argue that they already are providing these services in rural and other underserved areas, where few if any physicians are available. When viewed in such a context, it can be very difficult for a legislator to vote against a bill to expand scope of practice.

The current legislative session has seen many different professions attempt to expand their scopes of practice. Following are a few highlights of activity in the states in 2001 as of press time.

Advanced practice nurses: Two state legislatures—Maryland and West Virginia—passed bills permitting nurse practitioners to serve as primary care providers in HMOs. In the case of West Virginia, the governor signed House Bill (HB) 2389 into law April 30. In Maryland, however, the governor vetoed HB 473, even though it passed by a substantial margin in the House and by one vote in the Senate. In his veto message on the Maryland bill, Governor Glendening indicated he was concerned that HMOs might coerce consumers into choosing nurse practitioners over physicians, thereby eroding patient protections.*

Dentists: There were attempts in a couple of states to redefine the practice of dentistry. The Virginia legislature passed Senate Bill (SB) 806, which was signed into law on March 27. Under the provisions of this law, dentistry was redefined as the evaluation, diagnosis, prevention, and treatment—through surgical, nonsurgical, or related procedures—of diseases, disorders, and conditions of the oral cavity and the maxillofacial, adjacent and associated structures, and their effect on the human body. It also added a definition of “maxillofacial” that includes the jaws and face, particularly with reference to specialized surgery of this region.

Both the Medical Society of Virginia (MSV) and the Virginia Society of Plastic and Reconstructive Surgeons actively lobbied against this bill due to concerns that the redefinition of dentistry would permit single-degree oral surgeons to perform

plastic surgery of the face and neck. While repeal of this legislation would likely be unsuccessful in the 2002 legislative session, the statute requires that an advisory committee be formed to consult with the Virginia Board of Dentistry during the rulemaking process to recommend the education, training, and experience necessary to promote patient safety in the performance of these procedures. The advisory committee will include three representatives from the MSV, and three from the Virginia Society of Oral and Maxillofacial Surgeons. As such, physicians will still have a voice at the table.

Optometrists: Ophthalmologists are well-acquainted with efforts by optometrists to expand their scope of practice. State optometry associations have been very successful over the years in gaining the authority to use and prescribe diagnostic and therapeutic pharmaceuticals and to diagnose and treat glaucoma. In fact, over 150 bills dealing with optometric issues were introduced in state legislatures in 2001, and roughly two-thirds of those were related to scope of practice.

States where optometrists sought statutory authority to use pharmaceutical agents (oral drugs, controlled substances, injectable agents, and so on) were **Alaska, Georgia, Hawaii, Iowa, Massachusetts, Mississippi, New Jersey, New York, Oregon, Pennsylvania, South Carolina, Vermont, and Washington**. In addition, some states considered legislation permitting optometrists to treat glaucoma. These included Massachusetts and Vermont, which permit treatment, and **North Dakota** and **South Carolina**, which permit treatment without physician collaboration/safeguards. Of these, only the North Dakota legislation was signed into law on January 12.

Scope-of-practice issues at the state level can go both ways, though, as two examples illustrate. In **Florida**, the legislature considered but did not pass two bills (HB 553 and SB 924) that would have required postoperative care to be provided only by physicians. In **Illinois**, optometrists successfully secured the introduction and passage of SB 528 in order to prevent expansion of the scope of services provided by registered nurses, licensed practical nurses, or advanced practice nurses to include any acts, tasks, or functions that require professional judgment and that are primarily performed in the lawful practice of optometry. In ad-

* Desser M: Glendening vetoes bill on nursing. *SunSpot.net* (The Baltimore Sun), May 18, 2001.

dition, registered nurses and licensed practical nurses may only participate in the performance of refractions and other determinations of visual function or eye health diagnosis under the direct onsite supervision of a licensed optometrist.

Physical therapists: At least 20 bills were introduced in state legislatures in 2001 that would permit physical therapists to see patients without a referral from a physician, podiatrist, dentist, or chiropractor. The states considering this legislation were **Connecticut, Georgia, Indiana, Kansas, Mississippi, New York, Ohio, Oklahoma, Oregon, Pennsylvania, Virginia, Washington, and Wyoming**. Most bills did not pass, a few were still under consideration at press time, and one, Virginia's, was enacted in April.

Registered nurse first assistants (RNFAs): While RNFAs have not been seeking an expansion of their scope of practice at the state level, they have been working to obtain direct reimbursement for their services. In fact, a few states—**Florida, Kentucky, Maine, Minnesota, Rhode Island and Washington**—already mandate direct reimbursement. In 2001, nine states considered such legislation, with **Georgia and West Virginia** enacting direct reimbursement statutes. Other states still considering this legislation include **Louisiana, Massachusetts, Missouri, New York, North Carolina, South Carolina, and Texas**. In at least three of these states, the legislation is expected to pass.

Surgical assistants: Not all legislative proposals dealing with nonphysician health care professionals are clear scope-of-practice bills. In some cases, a group of nonphysician health care professionals may not even be licensed or simply may be seeking direct reimbursement for their services, as in the case of RNFAs. Three states considered legislation pertaining to surgical assistants this year. In **Illinois**, HB 48 would have required health insurance coverage for services provided by surgical assistants, and a separate bill would have licensed these practitioners. A bill in **Texas** would have licensed surgical assistants and, in **Virginia**, an attempt was made to create a state certification process for surgical assistants.

At the federal level

As mentioned previously, licensure and scope issues tend to arise at the state level. The focus at

the federal level is usually on payment or standards for participation in federal programs such as Medicare and Medicaid. Sometimes these efforts build on what is occurring in the states. For example, the Certified Registered Nurse Anesthetist (CRNA) issue described later in this article is a Medicare condition of participation matter that builds on state efforts to expand the scope of practice. Currently, 29 states do not require physician supervision for CRNAs.

CRNAs: By far the most contentious scope-of-practice issue facing the federal government is the supervision of CRNAs. A bitter turf battle between anesthesiologists and CRNAs came to the fore in 1997, when the Health Care Financing Administration (HCFA) first proposed lifting a federal rule governing standards for hospitals participating in the Medicare program, which requires nurse anesthetists to be supervised by physicians. The proposal, which would have deferred to an individual state's supervision laws, was finally approved in the closing days of the Clinton Administration. But soon after the Bush Administration took office, Assistant to the President and Chief of Staff Andrew Card issued a memorandum postponing the effective date until March 2001. It was then delayed for another 60 days, until May 18, 2001.

Finally, on May 17, Secretary of Health and Human Services (HHS) Tommy Thompson, announced that the rule would not go into effect as scheduled, and the department will soon introduce a proposal that contains two new points:

- A state governor could apply to HHS for a waiver of the supervision rule, provided it is consistent with state law and following consultation with the state's boards of medicine and nursing. The governor would also have to determine that removal of the supervision requirement is in the best interests of the citizens of that state.
- A prospective patient outcome study would be undertaken to compare the impact of different anesthesia practices by state.

In his statement, Secretary Thompson noted that "states have encountered interesting challenges in providing access to anesthesia services to all their citizens, particularly residents of rural areas or other areas with few anesthesiologists." With the new proposal, the governors of the 29 states who currently do not require physi-

cian supervision will be able to apply for a waiver to the new rule.

Under federal law, HHS must seek public comments on the new rule before finalizing it. The long-standing supervision requirement, therefore, will remain in effect for at least six months, and Medicare and Medicaid beneficiaries will continue to be guaranteed a physician's involvement in their care. For surgeons, the issue is to balance patient safety with the liability they assume when they supervise CRNAs.

Audiologists: Approved by the Food and Drug Administration (FDA) and currently under review by the Office of Management and Budget (OMB) is a draft proposed rule on hearing aid sales and dispensing. This proposed rule has not been released to the public, but, if enacted, it could allow audiologists to serve as the gatekeepers for access to hearing aids. Currently, first-time purchasers of these products must first see a physician, but adults who choose not to do so may sign a waiver indicating that they understand it is advisable to first visit a doctor. This rule could eliminate the requirements for signing a waiver or first seeing a physician.

The College agrees with views expressed by otolaryngologists that only physicians have the education, training, and clinical experience to establish the exact medical diagnosis and recommend appropriate treatment. Hearing loss is a symptom of a medical problem and appropriate management must be determined by a licensed physician.

RNFAs: As mentioned earlier, RNFAs are not seeking an expanded scope of practice at the federal level, but are working to obtain reimbursement for their services. Introduced by Rep. Mac Collins (R-GA), on March 1, the Medicare Certified Registered Nurse First Assistant Direct Reimbursement Act would provide direct reimbursement under the Medicare program for the surgical assisting services of certified registered nurse first assistants. Under current statute, only physicians and physician assistants are reimbursed for these services.

Grassroots advocacy

Because licensure and regulation of the health professions takes place at the state level, it is important for Fellows and their chapters to be in-

volved in grassroots advocacy whenever these matters could affect the welfare of surgical patients. As noted previously, many allied health professionals seek expansion of their scope of practice, often into areas that are within the purview of medicine. In an era when ensuring patient safety and preserving the physician-patient relationship are issues of increasing concern, expanding the practice authority of inadequately trained health professionals could have serious consequences.

Legislators realize they are not physicians, and most have no real understanding of the practice of medicine. They don't understand the significant education and training a physician goes through and the differences in education and experience between the various health professions. Therefore, they rely on the advice and opinions of medical experts when scope-of-practice bills are introduced. However, legislators are also responsive to their constituents, which is why nonphysicians have succeeded in expanding their scopes of practice. These groups achieve their goals because they are willing to commit to their cause, and they take the necessary time to contact their legislators in coordinated advocacy campaigns. They also are willing to contribute financially to their organization's advocacy efforts, because they know resources are needed for a campaign to work. And finally, there are a lot more of them in a legislative district than there are physicians.

Many of the scope-of-practice bills introduced this year were defeated due to the vigilance of medical organizations in their respective states advocating on behalf of their patients and their profession. The organizations were effective because their members took the time to call, write, or e-mail their own state legislators to encourage opposition to these bills. 

Author's note

The College purchases services from an Internet search company called Nexis.comsm, which searches legislation in all 50 states based on parameters focused on health care topics. Most of the information on state legislation contained in this article was identified through this service and is current through May 23, 2001.

What we can and can't do:

One surgeon's perspective

by Josef E. Fischer, MD, FACS, Cincinnati, OH

Not to sound alarmist, but there is a freight train headed down the track, and it's pointed directly at the fragments of what previously was a very good to excellent medical system. Others have referred to this as a coming tsunami, pointing out that those individuals who are on the ground do not often see the tsunami until it is upon them.¹ I warn of this coming train wreck because the signs are apparent. To wit:

- Medical school applications for the last five to seven years are down between 3 to 5 percent.
- The demography of medical school applicants has changed. Entire segments of society that previously considered medicine a noble and honorable profession no longer apply. While the quality of those applying for medical school remains good, it is only a matter of time before this shrinking pool will result in decreased quality of those practicing the medical profession. Who will take care of us as we get older?
- There is a nursing shortage. The average age of nurses in Ohio is 47. The University of Cincinnati (OH) Hospital currently has a nursing vacancy rate of greater than 20 percent. Deans of nursing schools broadcast their inability to recruit prospective nurses.

- The shortage of ancillary personnel, such as radiology and lab technicians, is even more acute.

- Anyone who can afford to retire from the medical profession is doing so. The age of retirement of surgeons has gone from 62 to below 60 years old. This represents a loss of individuals with acquired knowledge and experience who are at the peak of their careers, at least as far as their ability to recognize and treat disease.

- Surgeons of all specialties refuse to take call. The response thus far has been retrogressive application of the Emergency Medical Treatment and Labor Act (EMTALA). One cannot legislate individuals to continue to perform medical service to the indigent by putting them in jail. The continued demand for increasing unreimbursed care of the indigent, at a time when overhead for many surgeons' offices has now reached 60 percent of reduced reimbursement, is self-defeating. There is a limit to the indigent care that physicians can provide. Generally, we are willing to provide this care but are simply unable to do so and keep an office open and pay office staff so as to provide excellent patient care. The latter situation is not being helped by the increased demands for compliance audits and various regulations that work from the assumption that physicians are guilty until

proven otherwise—"the criminalization of medicine." As a result, many specialists are concerned about whether they will be able to appropriately educate their children—which is a concern that is, naturally, because of their own schooling, their highest priority.

The lack of support that physicians, and especially surgeons, have given to their offspring for entering a career in medicine, as well as the overall decrease in support of the medical profession to recruit and proselytize those who will follow in their footsteps, is due largely to a distressing angst and depression within the physician community. In what follows, I hope to point out that some of that angst is misplaced.

In consulting for various departments of surgery, I generally try to categorize problems into those that are soluble and those that cannot be remedied. Among the former are functional problems—relationships between individuals and relationships between divisions. Also possibly included in the former are certain structural problems.

However, there are also problems over which institutions may have no control and which cannot be altered. These include geographical problems, such as landlock, lack of room for expansion, or location in an unsafe part of town. These sometimes may be altered but, in general, are beyond the capacity for change. Occasionally, as in the case of the University of Cincinnati, a city-county hospital may be changed to a university hospital successfully despite the neighborhood, but that outcome is perhaps a rarity.

Finally, there are societal problems. These are problems that do not lend themselves to solutions by individuals, departments, or even medical centers. Medicine cannot fix them, should not be asked to fix them, nor, if asked, should accept responsibility for doing so. It is this latter area that I intend to address here, pointing out to my confreres that there are certain things we can do, and there are certain things that we cannot do. For the latter, we should not don the hair shirt if we cannot solve these societal problems.

Societal issues

Physicians always have been concerned with social issues. We are an altruistic group and, in general, have gone into medicine to help patients, heal

the sick, and care for society's ills. Over the past 10 to 15 years, physicians have accepted increasing strictures brought about by well-meaning but hopelessly misguided individuals. We have assumed truckloads of guilt for problems that are totally and completely beyond our control and that we cannot fix.

This situation, I believe, has led to considerable angst on the part of well-meaning physicians. They have despaired of solving these problems, and because they cannot resolve these issues, many have left the profession, retiring early or going into other walks of life. I do not believe that this is appropriate. I believe we should recognize that there are certain things that are beyond our ability to solve, and we should leave those matters to society to manage as they stem from societal decisions.

Primary among these problems is indigent care. Indigent care is frequently thrown at medicine as its failing. Some people assert that we are greedy, non-altruistic, and avaricious because we lack the desire to participate in the care of the indigent. This is a very easy argument to buy because, after all, we are the individuals who have to deal with these patients and care for them when they present in the late stages of their disease, often with far advanced malignancies that a regular schedule of appointment and a relationship with a primary care physician or nurse may have largely obviated.

To my way of thinking, if the indigent care problem is to be solved, the first thing that needs to happen is a reduction in the rhetoric. Second, we need to clearly identify the scope of the problem. Politicians commonly claim that there are 43 million uninsured individuals. In reality, the figure is much lower. The core figure for indigent care is between 16 and 20 million, certainly a figure that constitutes a problem, but not the 43 million patient figure so blithely broadcast. A review of this area has shown four notable facts:

- Included among the "uninsured" are young people who think they are invulnerable and would prefer to spend their money on material goods rather than purchasing health insurance. This sometimes reaches ridiculous extremes. I recently was asked to intervene in the care of a young man who has no health insurance but whose parents are extremely wealthy. He was injured in a skiing accident and was hospitalized at our institution.

He was treated, the physicians were never paid, and he is currently paying the hospital at the rate of \$25 per month. Shouldn't a wealthy family have a role in caring for their child? According to our society's current mores, apparently not.

- Another group of individuals who do not have health care insurance are single and recently divorced mothers who are gradually transitioning into the workforce through jobs, such as waitressing, that generally do not furnish insurance. Studies show that the members of this group rarely stay uninsured for longer than two years and very often obtain jobs that include medical benefits.

- There is a fairly large group who work for companies (generally small) that do not provide health care benefits or who are self-employed. While these individuals usually make a living wage, their inability to pay for health insurance means that any serious illness becomes an economic disaster. These working "medically indigent" individuals are not eligible for Medicare or Medicaid because they make too much money. Our institution and our physicians are asked to care for them gratis. Whether or not this is appropriate, I leave to the reader.

- The remaining group, and the largest one, is composed of individuals who are among the fourth generation of urban poor. These individuals have little or no family structure, and feel the hopelessness of seeing no way out of their current situation for either themselves or their children, given a lack of education and training in skills that would allow them to achieve an adequate standard of living. These individuals constitute the 16 to 20 million hard-core uninsured. They largely attain their care from academic medical centers and their staffs.

It has become increasingly difficult financially to treat this latter segment of the population, given reduced payments resulting from the Balanced Budget Act and the fact that managed care is doing away with those overages that would enable academic departments of surgery (and I assume other academic departments) to function while providing wholesale indigent care and supervising the residents. Such departments and faculty are absolutely unable to deal with this ever-increasing demand for free care. An estimated 70 to 85 percent of the costs of running an academic

department of surgery is salaries. Where is this money to come from?

There may be some detractors of what I am about to say, but I do not believe that organized medicine, or even disorganized medicine, or particularly individual institutions, academic medical centers, departments of surgery, or individual practitioners, can solve this problem. This is a societal problem. It will require a societal solution. Society has apparently decided that it does not wish to deal with the problem, that it wishes to pass off this problem on the medical profession, and that we should continue to take care of these patients free of charge while providing them the same level of care as we provide to patients for whom we get remunerated. Unfortunately, we have problems, too. We have secretaries, nurses, overhead, and rents to pay, and we have spouses and children for who depend on us to fulfill their economic needs. Further, all of these expenses now are taking a larger and larger percentage of our reduced remuneration.

Here, I think the message to society, to government, and to the surrounding social structure should be clear. We will do what we can. However, we do not think we can solve the entire problem. Medical indigence is society's problem, and society must take the responsibility for it. This recognition alone will reduce the angst among our brethren who believe that our inability to take care of the indigent is our fault. It is not. We have ever-decreasing resources and we must do what we can for our patients, who expect to and should receive a certain level of service. Increasing the number of patients we see, resulting in less time spent with each patient, is inappropriate and a prescription for poor medical care.

"Hamster health care"

A recent editorial in the *British Medical Journal* entitled "Hamster health care: Time to stop running faster and redesign health care," by Ian Morrison and Richard Smith, points out that physicians are having to see ever more patients, fill in more forms, and sit on more committees just to keep the various mismanaged governmental and other institutional programs afloat. Examples are the single-payor system in Canada, mandatory insurance systems in Japan and continental Europe, and the managed care systems in the United States.

Physicians believe they have to see more patients not just to maintain their income but, most of all, to support their overhead, which is now at least 60 percent of their remuneration. As this editorial states, "Systems that depend on everybody running faster are not sustainable....Many health economists see no problem with hamster care—after all, it is more service for less money. But a system that exhausts doctors and other healthcare (*sic*) professionals is not sustainable."² I agree. Furthermore, it results in poor care.

Many physicians see the hassles associated with the health care system as their most formidable problem, exceeding even their lack of remuneration and the need for tort reform. They would like to spend more time with their patients, realizing that unless they do so, the ability to take care of patients in a reasonable way will suffer. This is not a matter of greed. It is simply a matter of trying to practice what we have been taught about excellent patient care. As the editorial calls for the redesign of health systems, there is also another aspect to this that needs to be stressed: Physicians simply have got to start insisting on excellent patient care.

Resident work hours, indigent care, and training

Another club that organized medicine, and particularly surgery, is being beaten with is resident work hours. Most of us know that the index case for resident work hours, the Libby Zion case, was fabricated. The residents made the correct diagnosis. The attending did not come in. Sidney Zion, the parent, lied to the residents when they asked him specifically about cocaine toxicity, which he denied even though he had thrown the patient out of the house several weeks before for using drugs. Libby Zion's activities as a dealer at Bennington were well known. Nonetheless, New York State, utilizing the drumbeat of an undoubtedly guilty journalist, has passed resident work-hour rules that, from a surgical standpoint, interfere with the continuity of care.

It is perfectly possible to obtain first-class training while working only 80 hours a week. This would certainly be possible if all of the clerical activities—writing lab requests, drawing blood, transporting patients, and other onerous tasks that should be done by other support staff within hos-

pitals—were done by those support staff and not residents. Resident activities would then be limited to education and, in the case of surgical residents, taking histories and physicals, making rounds on the patients, assisting in the operating rooms, and attending educational conferences. Our own data suggest that this is easily within the capacity of most surgical residencies, including high-volume, busy ones such as our own.³

The problem with work hours, especially in academic medical centers dealing with large numbers of indigent patients, is that residents, particularly surgical residents, are the "shock troops" in the care of the indigent. Hospitals that have unfortunately taken poor contracts in an effort to gain market share, a practice that has afflicted most academic medical centers throughout the country, view residents as the cheapest source of labor available. This is understandable, particularly for patient care. However, residents also are forced to do social work, be transporters, be phlebotomists, fill out requisitions and lab slips, drag people down to X ray in the middle of the night, and so forth. This situation is even worse in urban academic medical centers in which large numbers of indigent patients are treated for little or no reimbursement.

This seems somewhat unfair. Society refuses, by and large, to pay for the care of the indigent and demands that attending staff take care of these patients free of charge. This is becoming increasingly onerous with imposition of EMTALA rules, which have been interpreted more generously and more widely by hospitals and consortia of hospitals. What is clear, however, is that society, having refused to pay for the care of the indigent, now turns around and demands that residents now work only a limited number of hours. Under those circumstances, we have a curious phenomenon—residents are dragged away from their educational activities; cannot give the continuity of care so vital to the training of residents, especially surgical residents; and perform all sorts of hopelessly non-educational tasks such as transport, phlebotomy, social work, and so on. In addition, the academic medical centers trying to take care of indigent patients are now being criticized for their inability to limit resident work hours.

If society does not want to pay for the care of indigent patients, it should at least stop criticizing the academic medical centers when they try to

take care of these indigent patients. Give us a break. Society does not want to pay for the care of indigent patients and beats us with the other hand for trying to take care of the indigent patients within the confines of the economic circumstances to which it has reduced us. The hypocrisy of society is nowhere more evident than in the issue of resident work hours.

What we can do

The essence of medicine is the physician-patient relationship. The physician-patient relationship consists of spending time with patients face-to-face, doing an adequate history, uncovering the symptom complexes, and performing an adequate physical examination. The history is paramount, the physical examination is confirmatory, and laboratory values and other investigations are confirmatory as well, provided one spends enough time with the patient to make an inferred diagnosis. The physician-patient relationship is something which cannot develop under the current system.

This is an area in which physicians can and should insist on doing something. Many physicians have taken the matter into their own hands, refusing to see Medicare patients or sign on for managed care—or actively obstructing managed care. In addition, some of the demands on physicians, especially in rural communities such as mandated by EMTALA, are being opposed in either guerilla-type warfare or by concerted action.

As I stated in a recent *Bulletin* article, there are a number of ways to deal with these various issues.⁴ Academic medical centers as well as many major medical organizations have failed to provide leadership on this issue. The emphasis on research in academic medical centers and the systematic “killing off” of individuals who heretofore have been seen as practicing excellent medicine, and the failure to reward excellent medical practice, have relieved the leadership of academic medical centers of the ability and the moral authority to deal with this problem.

Physicians and surgeons must rise up together or separately and give one consistent message: We will deal with what is our responsibility and with what we can influence. We will do what we can. “Hamster health care” is not what we want to do,

and we will no longer do it. The key to health care is an adequate physician-patient relationship. We accept that responsibility, and we will work toward creating that relationship and toward providing first-class care. We have an obligation to provide this care efficiently, to help design and institute critical pathways and best practices—that we can do.

However, societal issues are not our concern. We will help design societal remedies for unfortunate patients, but it is not medicine’s responsibility to implement the changes.

In the cold light of morning, perhaps then we can decrease our professional angst as far as the role of medicine and health care and return our function and our responsibility to where it needs to be focused—the care of the patient. Issues that are properly the domain of society we cannot and should not be expected to solve. By speaking out in this manner, we may not be able to stop the train, but we may be able to get it back on the right track. 

References

1. Washburn ER: The coming medical apocalypse. *The Phys Exec*, January-February 1999, 34-38.
2. Morrison I, Smith R: Hamster health care: Time to stop running faster and redesign health care. *Brit Med J*, 321:1541-1542, 2002.
3. Warner BW, Hamilton FN, Brunck BS, et al: Study of surgical resident working hours and time utilization. *J Surg Res*, 48:606-610, 1990.
4. Fischer J: Laying on of the hands. *Bull Am Coll Surg*, 86(1):24-28, 2001.

Dr. Fischer was until recently professor and chairman, department of surgery, University of Cincinnati (OH). He is professor of surgery designate, Harvard Medical School, and chairman of surgery designate, Beth Israel Deaconess Medical Center, Boston, MA. He is a Regent of the College.



Statement on diversity

The following "Statement on diversity" was developed by the Board of Governors' Committee on Chapter Activities and approved by the Board of Governors at its meeting on October 22, 2000. It was approved by the Board of Regents at its meeting on June 8-10, 2001.

The American College of Surgeons wishes to promote full participation in College activities by all surgeons: young surgeons, women surgeons, surgeons from minority groups, and surgeons from all practice venues. The College strongly supports and is committed to ensuring pluralism and equal opportunity which recognizes and respects the diversity of its members in order to maintain the highest standards of leadership in the profession. Specific recruitment of Fellows from underrepresented groups within the American College of Surgeons, including women, minorities, young surgeons, and private practitioners, is essential to maintain the strength of the College.

Furthermore, the American College of Surgeons will underscore this commitment to diversity by ensuring that meaningful positions of leadership within the College are held by Fellows derived from all groups of members, including young surgeons, women surgeons, surgeons of minority origin, and surgeons from all types of surgical practices. Nominations for leadership positions should be based on individual qualifications, willingness and ability to participate in and attend meetings, and expertise.

CyberSurgeon

Internet broadens surgical education environment

by Karen Sandrick, Chicago, IL

A virtual reality anatomy lecture with interactive, three-dimensional organs that can be drilled down to examine individual tissues and organelles, cellular and even anatomic structures. A holographic mannequin suffused with electromagnetic waves that can be touched and sliced into layers. Artificial intelligence that creates personal educational profiles that adapt the instructional environment to match a surgeon's style of learning and level of expertise.

"Surgeons will be sitting around in a room with a hologram in the middle of it, and they will be able to interact in different ways, taking a model of the uterus and blowing it up to the size of the room so, literally, in single file, they will be able to walk through the organ, look at the anatomy, and discuss where to make incisions. Surgeons will be moving beyond the educational environment of today to achieve what I term smart learning, which uses artificial intelligence to assess their learning styles, create a teaching environment that personalizes information, and changes the degree of difficulty to maximize their learning potential," says Jeffrey Levy, MD, assistant professor of obstetrics and gynecology, Jefferson Medical College, Philadelphia, PA.

Educational enhancements

These aspects of Internet-based surgical education will be commonplace in the next three to 10 years, Dr. Levy believes. "The Internet will give us a whole new realm of possibilities, possibilities of enhanced communication and education to level the playing field in the ways we teach our students and physicians. It's a key to interactive, flexible, and adaptive learning environments," he notes.

Dr. Levy is chief executive officer, chairman of the board, and chief education officer for MedCases, Inc., a Philadelphia-based electronic medical education company that teaches physicians by telecasting actual patient presentations over the Internet. A sample surgical case, for example, de-

scribes a 65-year-old woman with a history of diverticulosis who presents to the emergency department with constant, dull pain in the left lower quadrant, a low-grade elevated temperature, and anorexia for the last two days. It then guides the reader through an initial workup, differential diagnosis, laboratory and imaging tests, final diagnosis, and a treatment plan. The exercise is totally interactive and fluctuates according to the path the reader chooses. By including a built-in mentoring system, the MedCases system generates feedback to the reader throughout the discovery and decision-making process.

Currently, MedCases provides case presentations in five specialties: obstetrics and gynecology, pediatrics, family practice, internal medicine, and general surgery. In the coming months, the company will add case presentations for pulmonology and cardiology and will expand to cover 30 specialties in the next three years. MedCases offers subscription products to medical schools or clinical departments for students, interns, and residents as well as individual subscriptions for practicing surgeons that award 48 continuing medical education credit hours for completing four cases a month. The company also has produced prototypes for medical journals, textbook publishers, and specialty societies that simulate a patient encounter based on a review article, meta-analysis, chapter, or grouping of specialized cases.

MedCases' approach to teaching is not a new concept. "Problem-based learning has been around for over 30 years, and it's been experimented with or used in practically every medical school in North America at some point or another," Dr. Levy acknowledges.

What's different about MedCases is the interactive capability. "We're taking a new technology to enhance the process and create an environment where students can have self-directed learning, get as much as 80 pages of background material about a case from the literature, go into in-depth

mentoring, and obtain 50 or more pictures or video elements, all in one place," Dr. Levy explains.

Simulated surgery via computers

In the next three to five years, when the Internet drastically expands past current bandwidth constraints, it will bring virtual reality problem-based instruction to life. "Instead of just confirming for a surgeon that, 'yes, you chose the right procedure for this patient case,' the surgeon will be able to perform the procedure on a simulated patient over the Internet in a virtual reality experience. The patient will look real. There will be tactile and force feedback, so the patient will feel real. The surgeon will be using instruments that give the look and feel of an actual procedure. And the patient's outcome will be affected by how well the surgeon performs. So, if a patient has a bad result, the surgeon will have to deal with the complications," Dr. Levy adds.

Holographic education, an offshoot of virtual reality that is still in early development, will become one of the new frontiers for surgical education, Dr. Levy says. "When we put an image in 3D in the middle of a room and surgeons can interact with it, they essentially will be able to pull out components of a virtual cadaver, like the lungs, and look at them more closely, moving down the trachea to the bronchioles and finally to the alveoli. Surgeons will be able to immediately understand 3D anatomical structures and images by rotating them in different directions and zooming in and out," he observes.

A.I. to track ability

Artificial intelligence (A.I.), which is about 10 years in the future according to Dr. Levy, will individualize every component of surgical education by directing instruction according to a surgeon's learning strengths and weaknesses as comprehension improves and knowledge grows. "We're closer to getting artificial intelligence that can learn from what we do and that can potentially learn from our mistakes," Dr. Levy adds.

As an example, Dr. Levy poses the prospect of a run-of-the-mill written test. If an instructor gives a surgeon a 1,000-question test, he or she would have to check the answer to every question to decide how well the surgeon grasped the subject matter. With artificial intelligence, however, the in-

structor could track a surgeon's understanding through branching logic. The answer to each question would lead down a different branch to sets of questions that feed off one another and provide a picture not only of the surgeon's store of knowledge but his or her reasoning ability.

The same is true for teaching. "Artificial intelligence agents in the future will be able to determine a surgeon's level of learning and thought processing. It will learn from what surgeons do and take them down different branching points of teaching to make education more effective. It will figure out what type of educational experience works for a surgeon and change the teaching environment to bring it more in tune with how the surgeon gains intelligence," Dr. Levy says.

Artificial intelligence also will adapt instruction to a student's experience, tailoring information at different levels for first-year medical students and surgeons who have been in practice for 10 or 15 years and changing the degree of difficulty of educational programs to maximize the learning potential for every surgeon, he explains.

The Internet will provide the opportunity for telementoring so surgeons in their hospitals, homes, or offices can have an expert at their elbows to guide them through simulated procedures every step of the way. "The way to do this economically is to have a centralized mentor who can reach hundreds or thousands of physicians simultaneously throughout the world," Dr. Levy says.

When unlimited bandwidth frees the power of the Internet, surgeons will be able to access virtual reality and artificial intelligence anywhere. "Anything we can do on the most powerful computers in the world," Dr. Levy says, "we will be able to do at home." 

Ms. Sandrick is a medical writer in Chicago, IL.

Keeping current

Today in surgical practice: A conversation with Prof. Henrik Kehlet

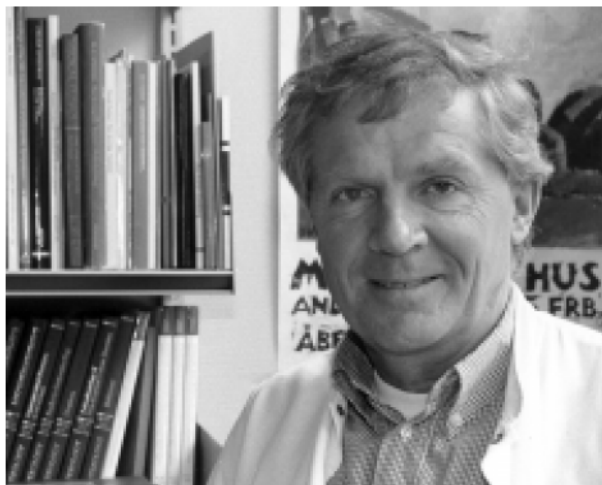
by Douglas W. Wilmore, MD, FACS, Boston, MA

Does the type of anesthesia significantly impact postoperative outcomes? In recent years, many surgeons have debated the effect of regional and general anesthesia on the risk of fatal or life-threatening events following surgery. But now a compelling meta-analysis by Anthony Rodgers and others featured in the *British Medical Journal* reveals evidence that may support more widespread use of regional anesthesia or neuraxial blockade in the surgical patient.¹

Following is a conversation with Prof. Henrik Kehlet, MD, PhD, co-investigator of this controversial meta-analysis, which answers questions regarding the impetus and implications of this investigation to surgical practice. Prof. Kehlet is chief surgeon, department of surgical gastroenterology, and professor of surgical gastroenterology at the Hvidovre University Hospital in Denmark. He is also a contributing author to *ACS Surgery: Principles and Practice*.

Q. What was the underlying impetus or purpose for the study?

A. Overall, the purpose of the study was to update current knowledge on the effect of regional anesthesia on postoperative morbidity and mortality. The methods implied identification of randomized controlled trials, comparing intraoperative neuraxial (epidural or spinal anesthesia) versus general anesthesia alone. For the purpose of this study, 141 (out of 158) eligible trials fulfilled inclusion criteria, including a total of 9,559 patients. Based upon overwhelming evidence to demonstrate that regional anesthesia may blunt several undesirable effects to surgical injury—such as endocrine-metabolic catabolic response, stress-induced pulmonary dysfunction, and increased cardiac demands—the study examined whether regional anesthesia, alone or in combination with general anesthesia, could positively



Prof. Kehlet

effect recovery and return to normal activity, and improve surgical outcomes.

Q. For which surgical groups were the benefits most pronounced?

A. It is important to note that differences were most pronounced in patients with major orthopaedic and other lower body procedures. Similar conclusions could not be found in major abdominal, urologic, and thoracic procedures or major intra-abdominal vascular procedures, since only a small number of studies were available. Therefore, the conclusions are applicable primarily to lower body procedures.

In the neuraxial blockade group, the study results showed a significant reduction in postoperative mortality, deep vein thrombosis, pulmonary embolism, myocardial infarction, bleeding and transfusion requirements, pneumonia, res-

piratory depression, and renal failure. The effect was clinically relevant, amounting to reductions in these complications that varied between 30 and 50 percent, compared with general anesthesia alone. A total of 247 deaths within 30 days were recorded in 35 trials, with overall mortality about one-third less in the neuraxial blockade group.

Q. Based on this analysis, what are the benefits of regional anesthesia for patients?

A. The demonstrated advantages of regional anesthesia are considered to be clinically important. In fact, the potential complications of regional anesthesia, such as hematoma and infection, are extremely rare (<1:15,000) and therefore not in proportion with the demonstrated positive effect of regional anesthesia as shown in this investigation. Study results also showed similar positive effects with a combination of regional and general anesthesia. There is uncertainty, however, about the net benefits of neuraxial blockade for some patient groups, such as for those with cardiac complications.

Although the study data were compiled from all available randomized trials, the information was collected over several years (1980 to 1998). However, a subanalysis showed no significant difference between the demonstrated results in the early versus the late study period. Nevertheless, the results may be modified and probably toward more advantageous effects, particularly when regional anesthesia is integrated into modern principles of postoperative care or what

is called fast-track surgery.² The concept of fast-track surgery combines various techniques used in the care of patients undergoing elective operations. A combination of approaches, including use of epidural or regional anesthesia, minimally invasive techniques, optimal pain control, and aggressive postoperative rehabilitation, work together to reduce the stress response and shorten the time to full recovery. Surgeons can learn more about the management of patients using fast-track surgery in an upcoming chapter of *ACS Surgery*.

Q. What general recommendations for surgical practice can be made on the basis of this study?

A. The results from this study should stimulate an increased use of regional anesthesia, and promote further collaboration between the anesthesiologist and surgeon to improve patient outcomes. Based on study results, regional anesthesia should be applied to lower body procedures whenever possible, and should be used in combination with general anesthesia or alone to reduce the parameters considered. Furthermore, the results should increase the awareness of surgeons to the positive physiological effects of regional anesthetic techniques, and to the potential of anesthetic techniques to improve surgical outcomes. Finally, it is important to perform further studies where regional anesthetic techniques are integrated in modern, multi-modal approaches (that is, fast-track surgery) to accelerate recovery and convalescence, thereby reducing morbidity and hospital stay. 

In *ACS Surgery: Principles and Practice*: Find out more about treatment guidelines for patients with "Postoperative Pain," a recent chapter by Drs. Kehlet and F. Michael Ferrante. And coming this fall, learn about the management of patients in "Fast-Track Surgery"—a new chapter by Drs. Wilmore and Kehlet. *ACS Surgery* is sponsored by the American College of Surgeons.

For more information on anesthesia and other topics in surgery, log onto WebMD® at www.webmd.com.

References

1. Rodgers A, Walker N, Schug S, et al: Reduction of postoperative mortality and morbidity with epidural or spinal anaesthesia: Results from overview of randomised trials (review). *Brit Med J*, 321(7275):1493, Dec 16, 2000.
2. Wilmore DW, Kehlet H: Management of patients in fast-track surgery. *Brit Med J*, 322:473-476, 2001.
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Dr. Wilmore is the Frank Sawyer Professor of Surgery, Harvard Medical School, Boston, MA. He is founding editor and editorial chair of ACS Surgery.

ACS scores success at AMA House of Delegates meeting

The College's delegation to the June meeting of the American Medical Association (AMA)'s House of Delegates (HOD) was successful in advocating for passage of a College-sponsored resolution titled "Claims Denial and Payment Delays." Because this resolution was unanimously adopted by the HOD, AMA policy now states that insurers should not deny payment for lost electronic or paper claims that are discovered after the required filing date when the physician has proof that the claim was filed in a timely manner. The AMA has also been directed to strongly promote this policy to third-party payors.

During the meeting of the AMA Young Physicians Section (YPS), the College introduced a resolution asking the AMA to undertake an in-depth study of the use and acceptance of CPT modifiers and code-editing packages by payors/insurers and that

the results of the study be used for AMA education and advocacy efforts. This resolution was unanimously adopted by the YPS and will be forwarded for consideration by the HOD at its next meeting in December. In a related matter, the HOD passed a resolution calling on the AMA to establish an information clearinghouse physicians could use to report information about administrative disputes they encounter with third-party payors. The collected information will be analyzed to identify trends and to facilitate effective, legally appropriate action by physicians and their representative organizations to solve administrative and payment problems.

The College lent its support to adoption of a report recommending approval of a draft Medicare preoperative medical evaluation policy. This policy clarifies that preoperative examinations and diagnostic tests performed for

the purpose of evaluating a patient's risk of perioperative complications and optimizing perioperative care are not currently included in the global surgical service and are separately payable by Medicare. The policy also notes that preoperative evaluations must not be viewed as routine screening services, although a claim can still be denied for any specific service or test deemed not medically necessary.

The College's delegation was led by LaMar S. McGinnis, Jr., MD, FACS (Atlanta, GA). Other delegates include: Charles W. Logan, MD, FACS (Little Rock, AR); Richard B. Reiling, MD, FACS (Columbus, OH); Amilu S. Rothhammer, MD, FACS (Colorado Springs, CO); and Thomas V. Whalen, MD, FACS (New Brunswick, NJ). In addition, the College was represented at the Young Physicians Section by Chad A. Rubin, MD, FACS (Columbia, SC).

Free consultation available at Clinical Congress

The American College of Surgeons' Health Policy and Advocacy Department will sponsor a practice management consultation booth during the College's Clinical Congress in New Orleans, LA.

Fellows with questions concerning practice management issues, such as coding and reimbursement, group mergers, and

contract negotiations, are welcome to make an appointment to arrange a free 30-minute consultation. The consultations are being provided by Tom Loughrey of Economedix, a highly regarded consultant in the field of practice management.

Appointments will be accepted on a "first-come, first-served" basis. Appointments will be

available from 9:00 am to 4:45 pm, Sunday, October 7 through Thursday, October 12, 2001. Please contact the College by September 25, 2001, to guarantee your private consultation.

To schedule an appointment, please contact Irene Dworakowski by calling 202/672-1507 or via e-mail at Idworakowski@facs.org.

American College of Surgeons

CAREER OPPORTUNITIES POSITION AND RESUME DATA BANK NOW ONLINE

A Career Opportunities Position and Resume Data Bank is now online on the American College of Surgeons' Web site at <http://web.facs.org/jobs/toc.htm>. The data bank is available to Fellows and resident and young surgeon members of the Candidate and Associate Society (CAS-ACS) and is being provided at no cost. It provides Fellows with a location for listing employment and fellowship openings, and with the ability to search a list of surgeons seeking employment or practice opportunities. CAS-ACS members seeking employment or fellowships can post their resumes and interests at no cost and can access the employment opportunity listings. All that is needed to use the data bank is an ACS membership identification number. For more information about this service or the CAS-ACS, contact Susan Grunwald at the ACS via e-mail at sgrunwald@facs.org or tel. 312/202-5231.

Young surgeon representatives gather in Chicago

by Charles C. Canver, MD, FACS, Albany, NY

A total of 68 representatives from 42 states, Washington, DC, and Puerto Rico attended the 30th annual Meeting of Young Surgeon Representatives March 10-11 at the American College of Surgeons' headquarters in Chicago, IL.

After opening remarks by Charles C. Canver, MD, FACS, Chair of the ACS Committee on Young Surgeons, Stephen R.T. Evans, MD, FACS, and Hugh M. Foy, MD, FACS, presented "Surgical Education: Principles and Practice." This presentation focused on the basic principles of teaching and learning in surgical specialties with audiovisual demonstrations of teaching methods that offered useful guidelines for surgeons involved in teaching. The course was followed by a dinner for the young surgeon representatives and their spouses.

The second day of the meeting began with remarks from Thomas R. Russell, MD, FACS, Executive Director of the ACS, who emphasized the importance of

the College throughout the duration of a surgeon's career. Henry R. Desmarais, MD, then Director of the ACS Health Policy and Advocacy Department, provided an update on the College's socioeconomic activities, namely those related to coding and state and federal legislation.

A panel presentation on "Surgeons As Teachers" followed. Erle E. Peacock, Jr., MD, FACS, gave an overview of informed consent for surgical procedures. Dr. Peacock provided day-to-day clinical scenarios facing practicing surgeons and explained the importance of making a sound habit of obtaining informed consent to minimize potential legal risks.

Next, Robert L. Parry, MD, FACS, outlined the state of Internet technology's use in medical practice. Dr. Parry said that Internet-based medical practice currently is being studied, but the uncertainty surrounding its legality remains. He also said there is an overwhelming amount of unsupervised

material on surgical procedures, and, while the availability of this information may lead to better patient education, its exact role in developing productive surgical practices remains elusive.

Max R. Langham, MD, FACS, then reviewed the process of enacting laws relating to surgical practice, emphasizing the importance of getting involved at local, regional, and national levels and of providing politicians with accurate information.

Dr. Russell closed the meeting with an overview of the College's operations, stressing the need for young surgeons to be actively involved in the College, both locally and nationally. Dr. Russell added that the College's strength lies in its diversity, and its primary focus is to give a voice to surgeons representing all specialties.

Dr. Canver is the Sheridan-Alley Professor and head, division of cardiothoracic surgery, director, The Heart Institute, Albany Medical College, Albany, NY, and Chair, Committee on Young Surgeons.

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Suggested reading

- Kehlet H, Holte K: Effect of postoperative analgesia on surgical outcome. *Brit J Anaesth*, 87, July 2001.
Kehlet H: Manipulation of metabolic response in clinical practice. *World J Surg*, 24(6):690-695, June 2000.

- Kehlet H, Werner M, Perkins F: Balanced analgesia: What is it and what are its advantages in postoperative pain? *Drugs*, 58(5):793-797, November 1999.
Kehlet H: Acute pain control and accelerated postoperative surgical recovery. *Surg Clin North Am*, 79(2):431-433, April 1999.

2002 Young Surgical Investigators' Conference

The Surgical Research and Education Committee of the American College of Surgeons has organized the Sixth Biennial Young Surgical Investigators' Conference to assist surgeon-scientists who are entering the process of obtaining extramural, peer-reviewed grant support for their work. The goal of these conferences, held with staff members of the National Institutes of Health (NIH) in attendance, is to introduce young surgeons to the process, the content, the style, and the people involved in successful grant-writing and interactions with the NIH.

The program will include intensive exposure to:

- NIH programs and policies
- Information from NIH Institutes
- What programs are best and available for your research project and how to apply
- Workshops in hypothesis testing, methodology, background, and preliminary results
- Grant-writing strategies
- Mock study sections reviewing model grants

The program and registration form are available online at <http://www.facs.org/dept/serd/srec/youngsurg.html>. For further information, contact Ms. Jan Fair, Administrative Associate, Education and Surgical Services Dept., American College of Surgeons, 633 N. Saint Clair St., Chicago, IL 60611; phone 312/202-5354; fax 312/202-5013; e-mail jfair@facs.org

March 8-10, 2002

*Lansdowne Resort
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Surgical Research and Education Committee of the
American College of Surgeons*

Seventh Triennial ACS Latin American Congress: Un gran espectáculo!

by Gerald O. Strauch, MD, FACS, Director, Surgical Education and Research Department

The Seventh Triennial Latin American Congress of the American College of Surgeons was presented by the Chilean Chapter of the College in Santiago, Chile, May 6-10. Held in the city's suburban Sheraton Hotel, the meeting was a success in every way. With a registration of 900 physicians and 147 nurses, its multidisciplinary sessions were well attended by enthusiastic audiences. Because more than 100 physicians from other countries were in attendance, the international flavor of the congress was unmistakable.

Juan Hepp, MD, FACS, President of the Chilean Chapter of the College, spoke during the congress' impressive opening ceremony on the evening of May 6. New Chilean Fellows of the College were introduced, followed by welcoming speeches on behalf of all of the Latin American chapters of the College by Augusto Paulino, MD, FACS, ACS Governor from Brazil, and by Ricardo Sonneborn, MD, FACS, ACS Governor from Chile. The author expressed the College's pleasure at again sponsoring the congress and acknowledged the excellent program that had been developed for it. I also offered a brief history of the College's role in surgery in Latin America, which was initiated in 1920 by the visit of Franklin H. Martin, MD, FACS, the founder of the College,

and William Mayo, MD, FACS, of the Mayo Clinic, to several countries in South America.

Sessions

The menu of sessions was impressive, reminiscent of the College's annual Clinical Congress, and covered every surgical specialty. Most sessions featured moderators from two countries, underscoring the international profile of the congress. Postgraduate courses, symposia, film sessions, and "free paper" sessions addressed virtually all of the topics of current concern to surgeons in the U.S. Strong emphasis on minimal access surgery, trauma, and oncology were apparent among the sessions dealing with surgical practice, but health administration, computer science (including a three-day practical computer course), surgical education, and effective conduct of surgical meetings were also subjects of major sessions. Socioeconomic issues were discussed at length and are obviously as much on the minds of surgeons in Latin America as their counterparts in the U.S.

U.S. attendees

As has been the case for previous Latin American Congresses of the College, six surgeons from the U.S., nominated by the program committee for the congress, were sponsored by the

College to attend the meeting. They were: Horacio J. Asbun, MD, FACS (Pleasant Hill, CA); Claude Deschamps, MD, FACS (Rochester, MN); Keith George-son, MD, FACS (Birmingham, AL); Erwin F. Hirsch, MD, FACS (Boston, MA); Carlos A. Pellegrini, MD, FACS (Seattle, WA); and Gerald O. Strauch, MD, FACS (Chicago, IL).

Potpourri

During the course of the congress, a useful meeting of Latin American ACS Governors was held to discuss current issues with reference to the College.

The congress was liberally supported by technical exhibits representing major book publishers, pharmaceutical companies, and manufacturers of surgical instruments and devices. A fine social program included, as its most attractive feature, a one-day visit to the home of the Nobel laureate poet Pablo Neruda, at Isla Verde, near the Chilean Pacific Coast.

In 2002, the Chilean Chapter of the College will celebrate its 50th anniversary. Easily identified as one of the College's most successful and prominent international chapters, its role as host to the Seventh Triennial Congress this year has provided a stellar prelude to its major celebration next year.



Letters...

The following comments were received via e-mail regarding "From my perspective" columns written recently by ACS Executive Director Thomas R. Russell, MD, FACS.

Collective bargaining

While I agree with the concept of collective bargaining for surgeons in order to provide a better environment for surgical care of our patients (May 2001), I'm disappointed that you did not mention the alternative of integrated care organizations such as Kaiser Permanente.

As a Permanente Medical Group general surgeon for the past 27 years, I can attest to the fact that all medical care decisions are made exclusively by the physicians. There are no such things as preadmission approvals, permission to order expensive imaging, specialty referrals including referrals to academic centers outside the medical program, or artificial length-of-stay restrictions. We have online access to care paths supported by outcome-based data, unrestricted availability of special lists, and staff support at all levels. Kaiser Health Plan, the HMO, restricts its activities to provision of facilities, staff, and equipment. All medical care decisions are made by the physicians for the benefit of our members.

Bruce R. Locke, MD, FACS

We seem to be missing the point when we discuss collective bargaining. What we should be doing is resigning from all contracts including Medicare and Medicaid. If all physicians had the courage, collective bargaining would not be necessary. We could go back to billing the patient and let the patients deal with their insurers just as things were 25 years ago. The first physician who said, "We'll bill your insurance for you," is the real culprit. Organized medicine

should encourage us all to seriously evaluate the contracting practice and resign.

Carl W. Wulfestieg, MD, FACS

Attracting surgical residents

I appreciated your last perspective (June 2001). Perhaps we need to be better role models for students and attract them to our specialty. My sense is that how students rate surgeons is what keeps them from wanting to be surgeons. Granted there are exceptions, but when more students are going into medicine because they are fascinated by the human body, and not people, you would think more would want to be surgeons. Perhaps when we start caring and stop dealing, start feeling and stop thinking, things will change.

Keep trying—your words will get through to some.

Bernie Siegel, MD, FACS

I read with interest your piece in the June *Bulletin*. Many of us in vascular surgery share your concerns about both the quality and quantity of applicants into our programs. We agree that part of the solution is more contact with medical students. The examples you gave of "in" specialties share something—they do not require five years of training in general surgery. Shouldn't we examine whether that same model could be used for other surgical specialties? The national organizations that represent vascular surgeons are about to critically examine training issues. I am delighted that this problem is now a concern for the ACS and hope that we can interact as new ideas emerge.

Richard M. Green, MD, FACS

How interesting that your perspective column appeared in the same issue as the letters from Drs. John N. Baldwin and George Lim, and the Dateline: Washington article on OSHA petitioning to regu-

late resident work hours. This brings the whole problem into focus rather well.

We must look at the present-day medical students/residents in the context of their interests and values. How do we then balance these with the requisites of training in these days of burgeoning information and technological advances—and make surgical training appealing to these persons? Quite a dilemma!

In recent studies, lifestyle and family time have gained in importance in the priorities of students and residents. While these mores differ from ours, we must respect that these are value judgments made by trainees and we have to work to include these in our teaching programs and curricula. These sentiments may seem strange to those who have put in long, arduous hours to become surgeons; these are the facts and we must acknowledge them.

I share Dr. Baldwin's concerns as a busy surgeon who is now a potential surgical patient. Yes, I desire to have a surgeon who has known the rigors of working after a night on call. What if my surgery is scheduled on a certain day; should I call to be sure that my surgeon is not on call the night before? What if he/she is called out the night before my surgery; should I insist on canceling and reschedule at another time when my surgeon is rested? A surgeon is trained to make proper surgical judgments in times of stress and fatigue. Our present-day training allows the trainees to learn to do this, learn that they can do this, and know what it is like to operate when weary. They must know that the sacred bond between the surgeon and his/her patient must be honored and dignified with an operation that is properly planned and implemented.

Our trainees must also know how sacred the responsibility of a surgeon to his/her patients is. The

mandate that a 24-hour period off per week may be counterproductive in the training of responsibility. If the first postoperative day of an esophagectomy or portacaval shunt coincides with the mandatory 24 hours off-duty, what message does that send to our residents? You can accept the responsibility of surgeon on a case, then walk off and not be emotionally and professionally involved in the patient's care?

I agree with your statements that we should not overburden students and residents with busy work, abuse, and unrealistic demands; we should maintain the excellence of our training in the cognitive and technical aspects of our specialty.

We are faced with a difficult juggling act. How we respond will influence our specialty, society, and health in the coming years.

**John C. O'Brien, Jr.,
MD, FACS**

Thank you for your perspective on early surgical education in the June *Bulletin*. We, the five surgeons in this community, are associated with first-year medical students. Our purpose is to provide students with an expressed interest in surgical specialties an active taste of what these practices are like in smaller towns.

We are with a student—one to one—one morning a week for about 10 weeks as an elective exposure to "rural medicine"—a pass-fail course. Our objectives have been to make them comfortable in the operating room, let them assist, learn to sew and tie knots, visit with the staff; but most importantly, make rounds with us, looking at films, lab values, and patients to gain insight to decision making and judgment.

During the 12 years we have participated, most of the students have been enthusiastic and have occasionally corresponded with us in

later years of their training to say that it reinforced or made their decision to pursue surgical training. This early exposure, interest in them by established surgeons, and acceptance as colleagues was pivotal in many of their career choices. I might add we have been excited and gratified by our participation as well. Thanks again for your stimulating comments.

John Stoianoff, MD, FACS

I appreciated your editorial expressing concern regarding recruits to the field of general surgery. I graduated from medical school in 1965 and I regret to say that many of my experiences were unpleasant, if not painful, and my choice of general surgery was made more in spite of than because of the "mentors" I had contact with in school. Worse yet, the experience I endured in residency was much the same or worse.

Most depressing of all is the fact that last spring our son graduated from the same school and, while in his surgical rotations, he frequently endured the same abuse and negativism I so painfully remember. It would seem that school has learned nothing is this particular area in the last 37 years. Your column's last section on strategies lays out the problem well. In this respect general surgeons are cutting their profession off at the knees.

I am pleased to report that even though our son had a miserable experience on his surgical rotations and initially chose family practice, after one year he realized his interests were in other areas and has now been accepted into an ob/gyn residency, the area he enjoyed most in medical school. We will never know what might have been his choice if his experience in his general surgical rotations had been more positive. Can the College do anything about this long-standing problem? I don't know. What about

interviewing medical students after their surgical rotations? Better yet—both before and after, rating the schools and publishing the results?

Carlyle D. Welch, MD, FACS

I read with interest your editorial in the June *Bulletin*. I am very concerned about the current status of medical students and their lack of desire to pursue a career in surgery, regardless of the specialty. As I look back on my own career, I realize that the most important factor that influenced my career choices were the outstanding role models I had at every level of my education. As a medical student, I was exposed to outstanding surgeons who loved their work and were very humanistic in their approach to their patients. They were tireless in their commitment to their patients and to the students for whom they were responsible. Most interestingly, in retrospect, I don't recall any one of my mentors ever discussing the financial aspects of a surgical career. Granted, in those days surgeons didn't have

Corrections

The "Fellows and facts" column of the June issue of the *Bulletin* incorrectly stated that George F. Sheldon, MD, FACS, delivered the 17th Hunterian Oration at the Royal College of Surgeons (Eng). The report should have indicated that Dr. Sheldon presented the 175th Hunterian Oration. Additionally, the last name of James O. Menzoian, MD, FACS, was incorrectly spelled as Menzonian. We regret the errors.

much to complain about for they were paid a handsome income. If one listens today, the subject of reimbursement is on every doctor's lips. What kind of example is this for the new bright-eyed student who is trying to choose a career path to follow?

Realistically, I don't believe there is any way to make surgical training easy. There is too much to learn and never enough residents with enough time in the day. There are certainly ways to improve the lives of surgical residents, as you mentioned in your article; and these changes are necessary. But, given quality instruction by an enthusiastic, kind, and committed surgeon, young students will once again find that a career in the surgical specialties provides some of the most unforgettable and rewarding experiences. The long hours and pay will be only secondary concerns.

Bob Szarnicki, MD, FACS

In the June *Bulletin* you asked for suggestions to stimulate interest in general surgery, again.

I can give you an example of why otolaryngology is easily filled. For a 45-minute outpatient FESS, Blue Cross/Blue Shield (BC/BS) in Iowa will pay around \$5,000 as the surgeon's fee for the procedure. For an endoscopic procedure of similar intensity, endoscopic cholecystectomy, BC/BS will pay around \$1,500 (perhaps not that much).

Ophthalmology has practically no weekends, holidays, or nights, and reimbursements are perceived as huge. Interest in urology I can't explain, since they have undergone massive cuts in Medicare reimbursements that represent their largest patient base. Perhaps it's the better hours.

My son has entered into a general surgery residency, but he has no plans to stay in the field. He intends to pursue a plastic sur-

gery fellowship later "to make a living."

My suggestion is to stop appeasing government bureaucrats and selling general surgery out. General surgery fees in Iowa have been reduced (constant dollars) by 65 percent between 1979 and 1999 (Medicare), and I perceive the ACS as largely responsible for allowing this to happen. I think \$5,000 for a routine FESS is excessive, but general surgery fees are now at the opposite extreme.

Kyle Ver Steeg, MD, FACS

Many excellent general surgical programs did not fill their positions because of a disproportional diminution in prestige and a devaluation of services in that discipline relative to the other specialties. Medical students see this and turn to less demanding and more profitable career choices. Why should they train for the high-wire act if the public pretends that manning the box office or refreshment stand is just as important and difficult?

Surgical training is intellectually and physically rigorous. It demands stamina, single-minded discipline, and courage. Candidates who are intimidated or overwhelmed by clinical experience probably ought not to be encouraged as they would not cut it as surgeons. Also, shielding candidates from a realistic picture of surgical practice, with its attendant broad responsibility and high risk, would be misleading.

Finally, the predicted shortage of general surgeons will serve to restore the high esteem and hence the desirability of a surgical career by invoking the law of supply and demand.

George Saj, MD, FACS

Just finished your last column on the shortage of general surgery residents.

I think I know something that

might help. Medical students are now selecting their careers while only in the second year. Therefore, any effort to encourage them to choose our specialty must occur sooner.

Boston University Medical School, as well as many others, offers an "integrated problems" course to all first- and second-year students. The class is divided into groups of six-to-eight students who meet once a week for two hours throughout the year. The program can only be accomplished with "volunteer physician mentors." I have been doing this for a year. It helps the students to be exposed to a general surgeon's perspective and may encourage them to pursue surgery. Most of the mentors are not surgeons.

Perhaps the College can promote this concept and increase the number of volunteer mentors who are general surgeons.

Vincent J. Russo, MD, FACS

I have always thought that more emphasis on the history of medicine with particular reference to surgery is stimulating if presented properly. The monumental advances in American surgery starting in the latter part of the 19th century phasing into the potential of a surgical interface with discovery at the molecular level should be of great interest to a student with an inquisitive and innovative mind. In addition, the programs should return to didactic lectures on the classical surgical diseases—these are interesting and stimulating if properly presented.

Robert J. Turner, MD, FACS



ACS launches CME Joint Sponsorship Program

The Office of Continuing Medical Education of the American College of Surgeons has announced the launch of a CME Joint Sponsorship Program. The program will be conducted by the ACS as a national accrediting organization under the Accreditation Council for Continuing Medical Education and will offer cost-effective joint sponsorship to not-for-profit surgical organizations nationwide for the CME programs and meetings.

Further information and application materials are available from the program's administrator, Kathleen Goldsmith, at JSP@facs.org.

Chapter news

by Rhonda Peebles, Chapter Services Manager, Organization Department

To report your chapter's news, contact Rhonda Peebles toll-free at 888/857-7545, or via e-mail at rpeebles@facs.org.

Ohio Chapter presents busy meeting

The Ohio Chapter conducted its annual meeting May 10-12 in Dayton, OH. The program included education sessions related to hernia repair, trauma and critical care, coding, and contract negotiations. In addition to the election of new officers (see top photo, right), highlights included: the presentation of the Distinguished Service Award to Sidney Miller, MD, FACS; the Ohio Oration, presented by John Preskitt, MD, FACS, a College Regent; and the President's Dinner, held at the Wright-Patterson Air Force Museum. In addition, the Ohio Chapter changed the name of its Socioeconomic Issues Committee to the Health Policy and Advocacy Committee and adopted a new mission statement:

The mission of the Ohio Chapter, American College of Surgeons, is to provide educational opportunities for its members, be an advocate for its members and the patients they serve, and support and uphold the standards of the American College of Surgeons.

Mexico Chapter adds Web site

The Nor-Occidental Chapter in Mexico went online with its Web site in May. The address is <http://caccno.org.mx>. Included on the Web site are a directory of Fellows in the Nor-Occidental Chapter and direct links to the College's Web site to apply for Fellowship.

Currently, 34 chapters have Web sites: Alberta, Arizona, Metropolitan Chicago, Chile, Colorado, Connecticut, Florida, Georgia, India, Indiana, Iowa, Kentucky, Louisiana, Maine, Metropolitan Washington, Mexico (Nor-Occidental), Michigan, Missouri, Nevada, New Hampshire, Upstate New York, North Carolina, Ohio, Eastern Pennsylvania, Southwestern Pennsylvania,



Ohio Chapter officers, pictured left to right: E. Christopher Ellison, Secretary; Joseph Crowe, President; Michael Nussbaum, Immediate Past-President; and Michael Stark, Treasurer (all MD, FACS). (Not pictured: President-Elect Robert Falcone, MD, FACS.)



Indiana Chapter officers, pictured left to right: Richard Graffis, President; Michael Dahlsing, Immediate Past-President; Inder Seekri, Secretary-Treasurer; and L. R. Scherer III, President-Elect (all MD, FACS).



Pictured with the Northwest Pennsylvania Chapter's 50th Anniversary Commemorative Charter are (left to right): Forrest Mischler, Governor; Keith Stephenson, Secretary-Treasurer; Kathleen Erb, President; and Paul Friedmann, the keynote speaker (all MD, FACS).

Puerto Rico, Rhode Island, San Diego, South Dakota, North Texas, Vermont, Virginia, Washington (State), and Wisconsin. To access all the chapter Web sites, go to <http://www.facs.org/about/chapters/chapmenu.html>.

Chapter anniversaries

Month	Chapter	Years
July	Southwest Missouri	49
	New Jersey	49
	Eastern Pennsylvania	49
	West Virginia	51
August	Georgia	51
	Hawaii	50
	Illinois	51
	Brooklyn-Long Island, NY	51
	Northwest Pennsylvania	50
	Rhode Island	50

Indiana Chapter conducts annual meeting

The Indiana Chapter held its annual education program and business meetings in Fort Wayne, IN. New officers were elected (see middle photo, previous page). Ronald Rosenthal, MD, FACS, a Regent, represented the College at the

meeting. During the business meeting, the Indiana Chapter members approved a bylaws amendment adding a new officer position to the chapter council, that of the Informatics Officer, which will be held initially by Wayne Moore, MD, FACS. Additionally, the members agreed to appoint an ad hoc committee to study the development of a fund for residents' research awards; this fund would be supported by contributions from Indiana Chapter members, as well as contributions from industry. Along with cash awards, the endowment would fund residents' participation at the Clinical Congresses.

50th anniversaries

During May 2001, two chapters observed their 50th anniversaries: the Alabama Chapter, which met May 10-12, and the Northwest Pennsylvania Chapter, which met on May 2 (see bottom photo, previous page).

Correction

In the June 2001 Chapter News column, a caption to one of the photos mistakenly identified the President of the Lebanon Republic, General Emile Lahoud, as Karam Karam, MD, FACS. We regret the error.

HAITI, from page 14

raculously, no patients died in spite of very serious diseases; we experienced no sepsis, no transfusions, no infections. I cannot recall a single complication.

We returned home with many new friends and many treasured memories. I will never forget the kiss I received from the woman with urinary incontinence or the smile on the boy with the bow-legs, now straight. I developed immense respect for those who devote their entire lives to helping these less-fortunate individuals. The Haitians proved to be a humble but noble people, who endure the degradation of poverty and illness with grace and acceptance.

Many friends have asked if I plan to return to Haiti. On the flight home, at a quiet time, this

thought came to mind: If I am given the opportunity, as my own death is imminent, to think back on perhaps five of the most meaningful times in my life, they would be my marriage to MaryEllen, the birth of my daughter, Erin, my graduations from medical school and surgical training, and my trip to Haiti. I have no choice but to return again and again. Not because I have so much to offer, but because this opportunity has given so very much to me. I was able to see the Lord in the faces of my Haitian patients. I was given the opportunity to operate on so many desperately poor, suffering people. Remember, He told us: "As long as you do it for one of these, the least of your brethren, you do it for Me." □

The *Journal* page

Message from the Editor

by Seymour I. Schwartz, MD, FACS, Rochester, NY

The inclusion of the 2000 I. S. Ravdin Lecture in the Basic Sciences by John A. Mannick, MD, FACS, in the September issue of the *Journal of the American College of Surgeons* reminds me of a unique consistency that pertains to the stewardship of the Peter Bent Brigham Hospital, the venue for Dr. Mannick's research and the institute where he chaired the department of surgery.

The consistency concerns the scientific bent of the three past chairs of that surgical department. First there was Harvey W. Cushing, MD, FACS, whose delving into the field of endocrinology led to his introduction of the terms "hyperpituitarism" and "hypopituitarism" and to the attachment of his name to a clinical disorder. He was honored with the presidency of the American Society of Endocrinology, in addition to the American Surgical Association.

And then there was Francis D. Moore, MD, FACS, whose seminal contributions to the field of surgical metabolism, and body composition in health and disease, dominated the field for decades. He, too, was honored with the presidency of the American Surgical As-

sociation. Dr. Mannick completes this intellectual triumvirate with his investigations in the realm of immunologic response to injury, coupled with his recognition as president of the American Surgical Association.

The very name of the month for this editorial manifests change and inconsistency. It was named the seventh month in the ancient Romulus calendar, which began in March, and became the ninth month with the adoption of the Numan calendar, which added January and February in the seventh century B.C.

It was on September 1, 1912, that Harvey Cushing, the first surgeon-in-chief of the Peter Bent Brigham Hospital, received his appointment as the Moseley Professor of Surgery at Harvard University. The lecture given by Dr. Mannick indicates that even in our changing world, islands of consistency remain.

Dr. Schwartz is Distinguished Alumni Professor, University of Rochester (NY) School of Medicine and Dentistry. He is also Editor-in-Chief of the Journal of the American College of Surgeons and a Past-President of the College.

INTRODUCTORY ABSTRACT from the September lead article

The Immunologic Response to Injury. John A. Mannick, MD, FACS, Mary L. Rodrick, PhD, and James A. Lederer, PhD. From the department of surgery, Brigham and Women's Hospital, Boston, MA.

Research on the immune consequences of shock and trauma by multiple laboratories over more than 20 years has resulted in the following paradigm, which is currently accepted by most investigators in this field: serious traumatic or thermal injury is quickly followed, after initial resuscitation, by the systemic inflammatory response syndrome (SIRS) which, in a sizeable minority of patients, will lead inexorably to the multiple organ dysfunction syndrome (early MODS) with an attendant high mortality. The majority of seriously injured patients survive the initial SIRS response without developing early MODS, and after a period of relative clinical stability, manifest a compensatory anti-inflammatory response syndrome (CARS) with suppressed immunity and diminished resistance to infection. Resultant infection and its attendant inflamma-

tion in turn may lead to multiple organ dysfunction (late MODS) and death.

This paradigm has several implications of potential importance in interpreting the sometimes conflicting results of research in this area: (1) An investigator's view of the immune consequences of serious injury may depend not only on what is being measured but on when the measurements are made. Serial observations are mandatory. (2) The inflammatory SIRS response, which occurs immediately after injury, is very unlikely to be caused by sepsis, but an inflammatory response that follows the CARS syndrome is very likely to be induced by invasive infection. (3) CARS is most probably the direct result of earlier SIRS. (4) Because the treatment of early and late MODS is largely supportive, it is reasonable to suppose that therapies directed at modulating SIRS and blocking CARS, preventing the onset of MODS, will prove to have more practical benefit to injured patients than efforts to treat MODS once it has begun.